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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

AUGUST 1985

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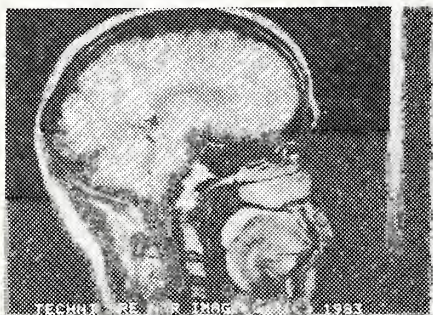
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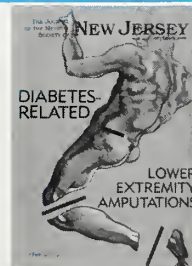
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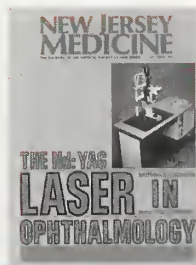
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On The Cover: The Nd: YAG laser is one of the most exciting developments in ophthalmology. Our cover story on this technological advance begins on page 787.



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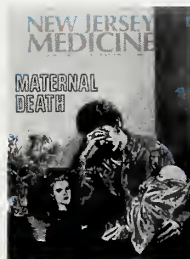
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On The Cover: Our cover story begins on page 871. All cases of maternal death in New Jersey are summarized by our authors and suggestions are made to help prevent such problems. Cover illustration by William Harmuth.



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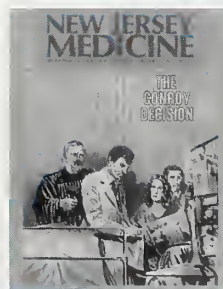
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On The Cover: The Supreme Court decision in the case of Claire C. Conroy represents a bold new advance in the development of legal medicine and health law. Our series of articles begins on page 945. Cover illustration by Will Harmuth.



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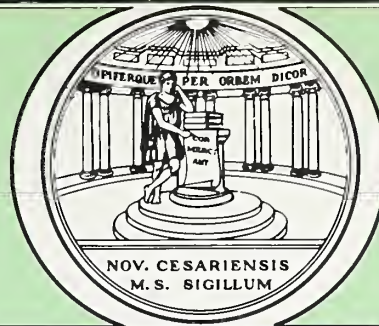
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MEMBERSHIP NEWSLETTER



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THE MEDICAL SOCIETY OF NEW JERSEY

VOLUME 25

ADVERTISEMENT OF SOCIETY OFFICE

The following Resolution was adopted by the House of Delegates at the MSNJ Annual Meeting in May:

Whereas, many physician members of the Medical Society of New Jersey have exercised their right to advertise their participation in various health plans, HMOs, PPOs, or like entities in advertisements for those entities; and

Whereas, identification of the physician as the present or former holder of an office or position in the Medical Society of New Jersey or a component society may lead the public to assume endorsement by the Society of such entity; now therefore be it

Resolved, that members of the Medical Society of New Jersey are precluded from proclamation of their position, present or former, in the Medical Society of New Jersey or component society as part of an advertisement for any health plan, fiscal intermediary, HMO, PPO, or like entity unless that entity has received the specific endorsement of MSNJ.

PHYSICIAN REIMBURSEMENT UNDER MEDICARE

The AMA opposed any continuation of the Medicare reimbursement limitations and fee freeze, arguing that: continuation would be inequitable and discriminatory; acceptance of assignment would be discouraged; physicians would be discouraged from treating Medicare beneficiaries; and selective increases in physician reimbursement would be inappropriate. This statement also discussed alternative physician payment methodologies and the long-range financial problems of the Medicare program that are in need of examination. The Association stated that it rejected basing physician payment on the basis of diagnosis related groups, and that the Association is "actively pursuing the development of a relative value study to establish resource cost-based relative values for physicians' services." In this testimony, the Association also raised concerns over the recent HHS action calling for sanctions against physicians in cases where physicians choose to waive collection of the deductible and coinsurance. (Testimony before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce, April 26, 1985.)

MEDICARE REIMBURSEMENT

The American Medical Association expressed the view that the "decision concerning whether a particular medical procedure can be safely and effectively performed in an ambulatory setting must be made by the patient's physician on a case-by-case basis to ensure quality patient care." The AMA stated that "Medicare should reimburse for a medical procedure performed on an ambulatory basis if it is safe and effective to perform the procedure in that setting." The Association, however, voiced its opposition to proposals that would permit "reimbursement for a particular procedure only if it is performed in an ambulatory setting." (Letter to Representative Edward R. Roybal, April 30, 1985.)

STRUCTURED INTERVENTION TRAINING

The Impaired Physicians Program, MSNJ, is sponsoring two-day intervention training seminars in northern, central, and southern New Jersey on October 16 and November 13; October 9 and November 6; and November 20 and December 4, respectively.

This course will train participants in the information, components, process, and skills necessary to conduct formal structured interventions with family, employers, or other significant persons in the life of the alcoholic (or chemically dependent person).

The workshop trainer is Rev. Edward Reading, Assistant Director of the Impaired Physicians Program, who has conducted this training program for more than four years and has trained more than 150 intervention specialists in New Jersey.

The cost for the seminar is \$60 which includes the two-day session, registration, training manual, and luncheons. Make your check payable to the Medical Society of New Jersey. Registration forms must be received by September 30, 1985.

REPORTABLE DISEASES

The following diseases are declared to be reportable to the State Department of Health for purposes of this code:

Acquired immunodeficiency syndrome (AIDS); amebiasis; anthrax; atypical mycobacterioses; babesiosis;

botulism; brucellosis, *Campylobacter fetus* diseases; dengue; diphtheria; encephalitis, infectious (specify); food/waterborne disease; giardiasis; Guillain-Barré syndrome; hepatitis—type A, type B, non-A, non-B, unspecified; hydatid disease; Kawasaki disease (mucocutaneous lymph node syndrome); legionellosis, including Legionnaires' disease; Pontiac fever, and diseases caused by atypical *Legionella*-like organisms; leprosy; leptospirosis; Lyme disease; malaria; measles; meningitis, infectious (specify); meningococcal disease; mumps; pertussis; plague; *Pneumocystis carinii* pneumonia; poliomyelitis; psittacosis; rabies; rat bite fever; relapsing fever, louse-borne; Reye's syndrome; rickettsial diseases, including Q fever, rickettsialpox, Rocky Mountain spotted fever, typhus fever; rubella (German measles), including congenital rubella syndrome; salmonellosis; shigellosis; smallpox; tetanus; toxic shock syndrome; trachoma; trichinosis; tuberculosis; tularemia; typhoid fever; venereal diseases—chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, ophthalmia neonatorum, and syphilis; viral hemorrhagic fevers including (not limited to) ebola, lassa, marburg; diseases caused by *Vibrio* species, including cholera; yersiniosis; and yellow fever.

The following diseases are declared to be reportable immediately by telephone in the manner described in 8:57-1.3, 1.4, 1.5, 1.6, and 1.10: botulism; cholera; diphtheria; food/waterborne disease; measles; meningitis, infectious, etiology: *Hemophilus influenzae*; meningococcal diseases; plague; poliomyelitis; rabies; smallpox; syphilis, infectious; and viral hemorrhagic fevers, including (but not limited to) ebola, lassa, marburg.

RESEARCH GRANTS—LUNG DISEASE

The American Lung Association of New Jersey offers research grant support in its area of interest, the prevention, and control of lung disease. The research may be laboratory, clinical, epidemiological, or other, but must be relevant to lung disease. Research grants are available in amounts up to \$5,000. No overhead charge is allowed. Support is for one-year projects, and is limited to research being conducted in the state of New Jersey.

Completed applications for the grant year beginning July 1, 1986, should reach this office by October 1, 1985. Grants will be made only to investigators working in institutions identified as Equal Opportunity Employers.

Applications must be submitted on standard forms. Forms may be obtained from American Lung Association of New Jersey, 2441 Route 22 West, Union, NJ 07083.

MEDICARE REIMBURSEMENT

On February 16, 1985, the Board of Trustees of the American Medical Association issued a statement on Medicare reimbursement, fee freeze, and needs of low-income Medicare patients.

The Board of Trustees voted: 1) to oppose the freeze on hospital reimbursement; 2) to oppose the continuation of the freeze on physicians' fees; 3) to oppose the freeze on clinical laboratory reimbursement; 4) to encourage physicians to accept Medicare "approved

amount" for payment in full for Medicare beneficiaries in financial need; and 5) to support an appropriate increase for hospital and physician reimbursement.

These positions are fair, equitable, and in the best interest of patient care, according to the AMA.

The Medical Society of New Jersey endorsed the February 16, 1985, statement of the Board of Trustees of the AMA as representing the position of the Medical Society of New Jersey, at its 219th Annual Meeting, May 2 to 5, 1985.

PREADMISSION REVIEW/CERTIFICATION

Preadmission Review/Certification in accordance with Title XVIII of the Social Security Act which applies to Medicare beneficiaries represents a direct reduction of Medicare benefits to citizens insured by Medicare. Medicare represents the most significant medical insurance to senior citizens who have paid for these benefits over many years, and has resulted in a situation in which Medicare has replaced most other forms of primary health insurance for senior citizens.

Preadmission Review/Certification is aimed solely at reducing the cost of medical care regardless of concern for the quality of medical care.

Preadmission Review/Certification represents an overt form of discrimination.

In the event the desired cost savings are not achieved through the presently established regulations, these regulations obviously will become more encompassing and restrictive in the future.

Preadmission Review/Certification, if established over a period of time, will become adopted by other third-party forces eventually to require Preadmission Review/Certification of virtually all hospital admissions, contributing to the undermining of the doctor-patient relationship and the demise of the American system of health care delivery resulting in a nationwide rationing of health care, such reduction of health care services producing a threat to the well-being of our patients.

The Medical Society of New Jersey is instituting a public relations campaign to educate the public as to the dangers inherent in Preadmission Review/Certification.

The Medical Society of New Jersey is advising its members to voice opposition to Preadmission Review/Certification.

The Medical Society of New Jersey is investigating through its legal counsel, the advisability of a legal remedy to the oppressive regulations of Preadmission Review/Certification and instituting such a course of action if found to be advisable by the Board of Trustees.

The Medical Society of New Jersey shall notify all legislative representatives of the state of New Jersey, both on a state and national level, of the Society's strong opposition to Preadmission Review/Certification.

The Medical Society of New Jersey shall present a similar resolution to the American Medical Association House of Delegates.

FINI

"Great people talk about ideas. Ordinary people talk about things. Small people talk about other people."

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
S-70 Codey	To change requirements for eligibility to be Commissioner of Health	Active Opposition	Senate: IHW	In committee
S-111 Bubba	To require a physician to present surgical consent forms at the time surgery is agreed upon	Active Opposition	Senate: LIP	In committee
S-243 Hagedorn	To provide procedures for involuntary civil commitment of the mentally ill	Active Opposition	Senate: IHW	In committee
S-424 Dorsey	To provide for the abolishment of certain state agencies for specific periods of time and to create a Joint Legislative Committee on Regulatory Agencies	Active Support	Senate: SGF&IR&VA	In committee
S-607 Bassano	To require the padding of all metal bars in school buses with energy-absorbing materials to be included in the State Board of Education's rules and regulations	Active Support	Senate: LPS&D	In committee
S-723 Brown	To require the State Department of Health to prepare a booklet on breast cancer and require physicians to give a copy of the booklet to breast cancer patients	Active Opposition	Senate: IHW	In committee
S-752 Hirkala	To provide that certain information of hospitals and long-term health care facility review committees be considered confidential	Active Support	Senate: IHW	In committee
S-754 Hirkala	To provide immunity from civil liability to members of hospital governing bodies in connection with certain review actions	Active Support	Senate: J	In committee
S-1067 Feldman	To establish and license two categories of social workers	Active Opposition	Senate: IHW	In committee
S-1079 Dumont	Provides for a 3-year statute of limitations, except for fraud, intentional concealment, or nontherapeutic or diagnostic purpose. Minors have until age 11 or any injury prior to age 8	Active Support	Senate: J	In committee
S-1112 Hurley	To establish a cap on the amount of damages which may be awarded for pain and suffering in certain civil actions	Active Support	Senate: J	In committee
S-1135 Dalton	To eliminate certain sources of windfall benefits in personal injury and wrongful death actions	Active Support	Senate: J	In committee

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
S-1140 Feldman	To impose certain requirements on the plaintiff in a medical malpractice proceeding	Active Support	Senate: J	In committee
S-1182 Saxton	To establish the Automobile Insurance Medical Fee Schedule Board	Active Opposition	Senate: LIP	In committee
S-1190 Feldman	To authorize a court to award reasonable attorney's fees to a party who prevails against a frivolous claim for relief in a civil action	Active Support	Senate: J	In committee
S-1775 Orechio	Allows chiropractors who are licensed to practice by written examination in any state and who have completed 4,300 classroom hours in a chiropractic school to become licensed to practice by virtue of a clinical examination	Active Opposition	Senate: LIP	Out of Assembly committee; 2nd reading
S-1840 Cardinale	Exempts the private practice of medicine from the certificate of need law	Active Support	Senate: IHW	In committee
S-1846 Garibaldi	Provides that cancers caused by exposure to heat, cold, radiation, or a known carcinogen which manifest themselves in active police or firemen are assumed to be accidental and work-related disabilities	Active Opposition	Senate: SGF&IR&VA	In committee
S-2019 Lynch	Creates the profession of contact lens dispensing and fitting for nonphysicians and nonoptometrists. Licensure and regulation would be through the Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians. A prescription by a licensed optometrist or physician would be required	Active Opposition	Senate: LIP	Out of committee; 2nd reading
S-2116 Bassano	Requires physician to inform women undergoing abortions of availability of fetal anesthesia whenever the fetus to be aborted is viable, i.e. able to live outside the womb with or without artificial means of support. Act is not applicable during an emergency, or if the anesthesia decreases the possibility of survival of fetus, or if the anesthesia to the mother will also abolish organic pain to the aborted fetus.	Active Opposition	Senate: LIP	Out of committee; 2nd reading

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
S-2159 Hagedorn	Substantially alters the involuntary commitment law. Significantly, certification may be effected by psychologists, nurses, or social workers who have conducted examination within the three days prior to certification	Active Opposition	Senate: J	In committee
S-2379 Costa	Provides that consulting physicians are not to be reimbursed unless patient has agreed, in writing, prior to consultation. Substantial incapacity of patient and mandatory consultation as a result of law, hospital rule, or insurance contract are excepted	Active Opposition	Senate: IHW	In committee
S-2544 Bubba	Requires express written consent to surgery except in cases of physical or mental incapacity or emergencies. The State Board, after consultation with the Health Dept., MSNJ, and NJHS, shall prescribe the consent forms which shall be used by physicians	Active Support	Senate: LIP	In committee
S-2869 Codey	Amends certificate of need to include physicians whenever a health service has been regionalized by regulation of the Dept. of Health. Regulation would terminate within three years, at which time, the Commissioner could readopt the regulation	Active Opposition	Senate	Out of committee

LEGISLATIVE ALERT

S-2869-Codey—Health Care Facilities Act/Certificate of Need. S-2869 has been reported out of committee. This bill presents a clear and present danger to the private practice of medicine. Every member of the Medical Society of New Jersey should write and call their Senator and Assemblymen and request a "NO" vote on this bill.

A-115 Otlowski	To authorize optometrists to prescribe a limited number of eye medications	Active Opposition	Assembly: HERP	In committee
A-708 Hardwick	To create a temporary committee to study Diagnosis Related Group System used for setting hospital rates and appropriate \$45,000	Active Support	Assembly: CHHS	In committee
A-926 Weidel	To create an Automobile Insurance Fee Schedule Board in the NJ Dept. of Insurance to adopt a reasonable fee schedule for medical services arising from passenger automobile accidents	Active Opposition	Assembly: BI	In committee
A-960 Miller	To permit individual patients or insurers to appeal hospital bills in cases of assignments under the Diagnosis Related Groups	Active Support	Assembly: CHHS	In committee

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
A-963 Miller	To eliminate the Diagnosis Related Groups methodology and replace it with one to be devised by the New Jersey Department of Health in one year	Active Support	Assembly: CHHS	In committee
A-1056 Muziani	To require attending physicians and certified nurse midwives to inform pregnant women of any drugs expected to be used during pregnancy and the possible effects thereof	Active Opposition	Assembly: CHHS	Out of Senate committee; 2nd reading
A-1116 Patero	To permit licensed psychologists to certify disability under Temporary Disability Benefits Law	Active Opposition	Assembly: L	Out of committee; 2nd reading; amended
A-1158 Herman	To require licensed physicians or chiropractors to notify the State Board of Medical Examiners if they accept Medicare assignments	Active Opposition	Assembly: HERP	Out of committee; 2nd reading; amended
A-1471 Garvin	To require a physician to obtain, in advance, the patient's authorization to perform a biopsy or mastectomy	Active Opposition	Senate: IHW	Signed into law as c. 185 P.L. 1984
A-1541 Karcher	To provide for the licensing of persons who practice hypnosis and limit the practice, teaching, or preparation of hypnosis tapes to licensed practitioners	Active Opposition	Assembly: HERP	Out of committee; 2nd reading; amended
A-1559 Garvin	Requires Dept. of Health and the State Board of Medical Examiners to prepare a booklet on all aspects of the treatment of breast cancer. Physicians are required to distribute the book to appropriate patients and to discuss it with them	Active Opposition	Assembly: CHHS	Out of committee; 2nd reading; amended
A-1682 Muhler	Creates a seven-person Board within the Department of Human Services vested with the authority to release or continue the commitment of persons who were found incapable of standing trial or not guilty by reasons of insanity. A Superior Court judge currently makes these decisions	Active Opposition	Assembly: CHHS	In committee
A-1870 Garvin	Amends existing statutes to require either seat belts or restraint systems for all children under ten in a motor vehicle. Current law applies to children under age five	Active Support	Assembly: CI	In committee

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
A-1921 Miller	Establishes a 3-year statute of limitations in tort actions against health care providers. Children would have until age 11 to bring action for injuries prior to age 8. After age 8, they come under the 3-year standard. Fraud, concealment, and unintentional foreign bodies "toll" the statute	Active Support	Assembly: JUD	In committee
A-1922 Miller	Provides that within 60 days of filing a medical malpractice complaint, the plaintiff must supply an affidavit, by a qualified expert, that reasonable cause exists to believe malpractice occurred	Active Support	Assembly: JUD	In committee
A-2115 Otlowski	Permits optometrists to use topical drugs for treatment and diagnostic purposes	Active Opposition	Assembly: CHHS	Returned to committee
AR-31 Herman	Requests the Commissioner of Health to educate the public, particularly young people, about the dangers of cigarette smoking	Active Support	Assembly: CHHS	In committee
A-1918 Miller	Provides that collateral sources of payment shall be used to offset damages. Further provides structured payments may be used at the request of either party if the future damages exceed \$100,000	Active Support	Assembly: JUD	In committee
A-1919 Miller	Provides a \$100,000 cap on damages for pain and suffering to personal injury actions	Active Support	Assembly: JUD	In committee
A-2106 Paterniti	Requires nursing homes with 100 beds or more to dedicate 10 percent of bed capacity to indigent, 10 percent to complex care, and 10 percent for medical day care services	Active Opposition	Assembly: CHHS	In committee
A-2122 Cooper	Establishes seating restraint and emergency exit requirements for school buses	Active Support	Assembly: ED	In committee
A-2293 Kalik	Appropriates \$9.45 million for the UMDNJ Osteopathic School in Stratford	Active Opposition	Assembly: RFA	Signed into law as c. 4 P.L. 1985
A-2304	To require that the driver and passengers in the front seat of an operating passenger automobile wear the safety seat belt provided	Active Support	Assembly: LPSD	Signed into law as c. 179 P.L. 1984

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
A-2140 Rooney	Provides that a judge may order a juvenile offender to be examined by a physician, optometrist, or audiologist	Active Opposition	Assembly: JUD	Out of Senate committee; 2nd reading
A-2757 Kern	Empowers the SBME to license and regulate nurse-midwives. Creates five-member Nurse-Midwives Examining Committee which would have the power to license and regulate nurse-midwives. Committee would have stipulated, delegated powers from Board and would function independent of Board	Active Opposition	Assembly: HERP	In committee
A-2889 Herman	Provides for separate licensing board to register physician assistants who would function under the supervision of a licensed physician at the 2:1 ratio	Active Opposition	Assembly: CHHS	In committee
A-3110 Hardwick	Provides for structured payments in cases exceeding \$100,000 liability in future damages. Prohibits punitive damages in medical malpractice cases	Active Support	Assembly: JUD	In committee
A-3111 Hardwick	Requires the Court to award attorneys fees to the prevailing party if the other side has been guilty of frivolous actions	Active Support	Assembly: JUD	In committee

Senate Committee Key

ED:	Education
IHW:	Institutions, Health and Welfare
J:	Judiciary
LIP:	Labor, Industry and Professions
LPS&D:	Law, Public Safety and Defense
SGF&IR&VA:	State Government, Federal & Interstate Relations & Veterans Affairs

Assembly Committee Key

BI:	Banking and Insurance
CHHS:	Corrections, Health and Human Services
CI:	Commerce and Industry
ED:	Education
HERP:	Higher Education and Regulated Professions
JUD:	Judicial
L:	Labor
LPSD:	Law, Public Safety and Defense
RFA:	Revenue, Finance and Appropriations

MedAC

Medical Action Committee

Dear Colleague:

Two years ago we asked you to respond by helping finance an emergency legislative campaign fund which we called **MedAC** (Medical Action Committee)—and respond you did! Unlike past state elections, the 1983 legislative campaign saw organized medicine become an important factor because of **MedAC** and our well-established JEMPAC program.

Because of these efforts and our continuing legislative programs, a new respect for medicine appears to have developed in Trenton. We cannot minimize the effect of our financial participation in legislative election campaigns. Medicine remains under continued assault from a variety of ancillary professions who would like to practice medicine in one form or another and/or erode the public safeguards that existing laws have established against such practice by those not adequately educated.

On other fronts, we continue to face the threat of increased regulation, ranging from government developed fee schedules for treatment of automobile accident victims, to the legalization of physicians' assistants, to the problems of DRG's, and many other questions.

In the past two years, medicine has been able to withstand all of these challenges. Now, another state election is upon us. New Jersey will be electing a governor and all 80 members of the Assembly.

Because of the success of the **MedAC** effort in 1983, we are renewing our appeal to all members to make a special contribution to be used only for state election activities.

Please send your contribution of \$100 or more, written on your personal or professional corporation check to either **MedAC** or **Medical Action Committee**. If you use your personal check, one-half of the contribution to **MedAC** can be taken as a federal tax credit to a maximum of \$100 on a joint return or \$50 on an individual return.

Please take this crucial action today!

Sincerely yours,
Ralph J. Fioretti, M.D.
President

Medical Society of New Jersey

Two Princess Road
Lawrenceville, NJ 08648
609-896-1766



Potential Suits and Settlements

Radiology Claims; Malpractice Settlement in New Jersey; Psychiatrists' Coverage; Did You Know?

NORCAL Mutual Insurance Company of California has found that "failure to diagnose" is the

most common allegation against radiologists. To aid in minimizing the potential claims, NORCAL offers the following suggestions:

1) Establish Rapport with the Patient. In the limited time available, do your best to establish a positive doctor/patient relationship. Make the patient feel a part of the process by introducing yourself, explaining the procedure, and asking the patient if he/she has any questions.

2) Informed Consent. Review your procedure to be certain that you cover the major risks, benefits, and alternatives. It is appropriate and helpful for the attending physician to discuss briefly the procedure and alternatives prior to referring the patient to the radiologist. Ask the patient if any discussion took place with regard to alternatives. Prepare written handouts with pre- and post-test instructions, whenever possible, to reduce errors in communication.

3) Maintain Good Records. Dictate your reports promptly, particularly if the report is on an interventional or invasive procedure. Always proofread a report before signing it. If the patient reports a complication or calls for advice postexamination, document this by an addendum to your radiology report.

4) Standard of Care. Be aware that the "standard of care" is not modified by the cost-containment efforts of insurance carriers and health care providers. There

was a substantial settlement against a southern California therapeutic radiologist who did not use computerized tomography prior to instituting radiation therapy when the group plan would not pay the cost. (*NORCAL Claims Rx*, a publication of NORCAL Mutual Insurance Company, Vol. 6, No. 2, April 1985)

\$16.7 MILLION MALPRACTICE SUIT

A brain-damaged, severely handicapped 4-year-old boy could receive more than \$16.7 million over the next 64 years under a settlement reached by his parents with a New Jersey hospital and two physicians who helped deliver the child. The settlement—believed to be one of the largest of a medical malpractice case in New Jersey—arose from a lawsuit by the boy's parents, who charged that the doctors and a nurse disregarded signs during labor that the baby was suffering a lack of oxygen. As a result of the negligence, the parents contended, the child has a severe form of cerebral palsy that causes tremors and spasms in all four limbs.

The settlement provides lifelong payments to the boy. The tax-free payments are guaranteed to continue for 30 years, totaling \$3.7 million, even if he dies before that time. He would receive \$16.7 million if he achieves a normal life expectancy of 68 years.

The settlement also provides annual tax-free payments of \$30,000 to each of his parents for at least 30 years, which amount to \$1 million for each.

Superior Court Judge Kevin M. O'Halloran, who handled the case, ruled before the trial that the father as well as the mother could seek damages for emotional distress because he had stood by his wife in the delivery room and witnessed the baby's birth on January 7, 1981.

The parents had taken a Lamaze childbirth class which taught them how to watch for warning signs, and they first expressed alarm about the baby's abnormal heartbeat to a nurse, according to O'Halloran.

The baby was delivered with the umbilical cord wrapped tightly around his neck, the judge's ruling states. The infant was motionless, and his skin was blue.

Under the settlement, the parents also would get an immediate \$370,000 to buy a home equipped to accommodate the handicapped child and for other expenses of his treatment and care.

In his ruling that both parents could seek damages separate from those of the child, O'Halloran states that the parents in their Lamaze course "had learned to be active members of the birthing team."

O'Halloran found that the parents understood the role of the fetal heart monitor, an ultrasound device intended to alert physicians to fetal distress, such as the loss of oxygen due to compression of the umbilical cord.

Signs of such distress often lead doctors to deliver the baby immediately by cesarean section, thereby avoiding further oxygen loss which might result in permanent brain damage.

On several occasions while the mother was in labor,

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Director of Special Projects.

both parents "noted that the fetal heart rate on the readouts was abnormal," the judge wrote. "On these occasions the father notified one of the nurses. They were both anxious about this and were given further cause for concern when the mother was given oxygen without explanation. Both parents witnessed the birth of the child and saw the umbilical cord wrapped tightly around his neck and that the infant was not breathing, but was cyanotic, purplish blue all over," O'Halloran wrote. "They thought the child was dead."

The parents alleged that failure by the nurse and physicians to recognize and react to signs of the cord compression resulted in asphyxiation of the infant, causing cerebral palsy.

The parents claimed that administration of a spinal anesthesia to the mother delayed delivery and thus caused further damage. They also alleged that the staff did not adequately resuscitate the baby. (*The Record*, Sunday, April 14, 1985)

PSYCHIATRISTS DROP "UNDUE FAMILIARITY" COVERAGE

Reasoning that psychiatrists inclined to take advantage of their patients might think twice about it if they had to pay for any resulting judgments against them for sexual misconduct, the American Psychiatric Association is dropping from its member malpractice insurance plan any coverage for "undue familiarity." The program with RLI Insurance Group, Peoria, Illinois, still will defend in court insured physicians who deny allegations of sexual misconduct, but effective May 1, the policy no longer will pay for judgments for such misconduct against insureds. APA's benefit administrator, Martin Tracy, said, "APA feels that it shouldn't sponsor a program to condone unethical activity," and noted that charges of "undue familiarity" accounted for 17 percent of the malpractice claims

filed under APA's former insurance plan with Chubb & Sons. RLI assumed coverage for APA's 10,000 members May 1, 1984.

The other driving force behind the change relates to rising rates. APA's Director of Member Benefits, Beverly Patrick, said insurance companies' premium quotes are 25 percent higher now when they include coverage for sexual misconduct. Even without such coverage, APA's rates will increase 7.5 percent on May 1, but that increase relates to overall claims experience. Tracy said. Average yearly premium for a psychiatrist is \$1,100.

To discourage sexual misconduct between psychiatrists and patients, APA is providing an educational videotape and guidebook for medical students, residents, and practicing MDs, teaching how to deal with sexually charged patient situations. The APA's Committee on Women may launch an independent survey to determine the extent of professional sexual misconduct. (*Medical Liability Monitor*, Vol. 10, No. 3, March 29, 1985)

DID YOU KNOW . . .

Professional liability problems are mounting for psychiatrists and other mental health professionals, although insurance experts say such claims are less frequent and severe than in general medicine? Insurers are dropping out of the market, and rates are escalating. In recent years, premiums have increased between 25 and 40 percent, according to the American Psychiatric Association. Meanwhile the APA says its insurance plan no longer will pay awards or settlements handed down in unethical-liaison suits, although it will cover the cost of defending such charges. Sex-related lawsuits, the Association says, now account for about 15 percent of the total liability claims paid. (*Medical Economics*, April 1, 1985)

New Jersey Medicine

Our award-winning journal has a new title, New Jersey Medicine.

Doesn't the title—*New Jersey Medicine*—have a simple and direct ring? The Board of

Trustees approved our name change, which was recommended by the Publication Committee, the Editorial Board, the editor, and the staff.

A good deal of research, graphic experimentation, and discussion was required before we made the giant leap forward. We believe that, like one's own name, the name of our journal should be personal and should reflect the sponsoring organization and the content.

The Journal of the Medical Society of New Jersey is a cumbersome and somewhat dated appellation. But, this transition does not happen without deep inner searching and some misgivings. Progress often entails giving up something—even an old friend—on occasion. Don't you feel a slight pang when you trade in your old car for a new model? Especially if it has served you well?

Volume 1, No. 1 of *The Journal* was first published under the direction of the Committee on Publication as ordered by the Board of Trustees in September 1904. Richard C. Newton, M.D., of Montclair was the

first editor. Prior to *The Journal of the Medical Society of New Jersey*, we had the *Transactions of the New Jersey Medical Society* which was born July 23, 1766, as a handwritten record from the formation meeting at Duff's Tavern in New Brunswick.

The transition in our publication has been striking. From an oft-ignored monthly magazine, our award-winning publication has undergone many changes, which our readers seem to accept in good grace. Keeping up with—or ahead of the times—is the driving force toward improvement, so a name change appeared to be the very ticket for further attractiveness to our readers, our advertisers, and our contributors. The full title, *New Jersey Medicine, The Journal of the Medical Society of New Jersey*, gives us full recognition yet a modernized moniker which should carry us into the 21st century.

Undoubtedly, we will hear pros and cons from our readers. For those who may be less than happy about the change, you have my permission to pour a bottle of champagne over the editor's head—if you're fast enough to catch up to him.

A.K.

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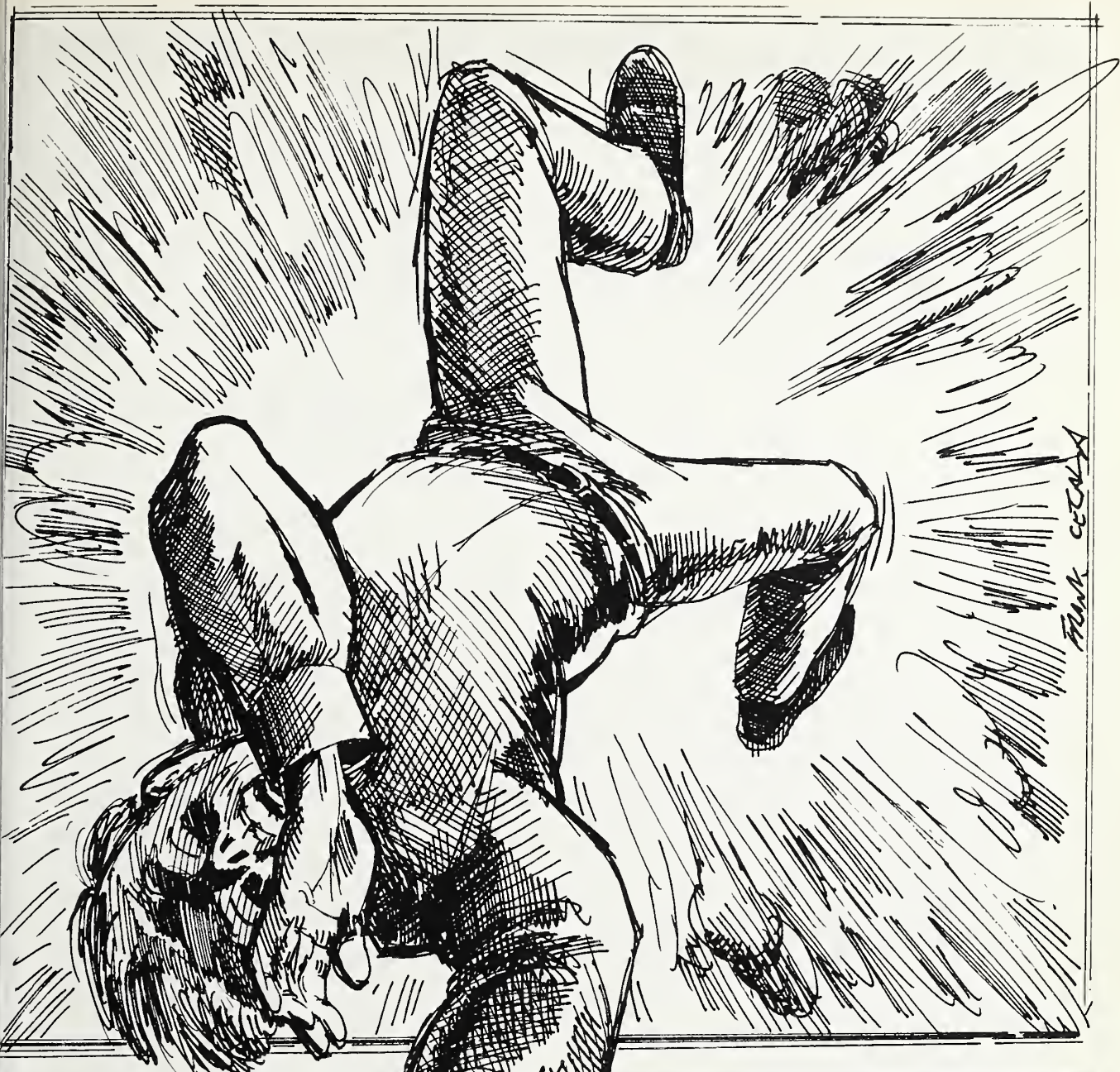
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CASE REPORT

LEFT ATRIAL

RUPTURE

SECONDARY TO

BLAST

INJURY

Cardiac injury secondary to nonpenetrating trauma is well documented. Our patient suffered blunt trauma from an explosion which ruptured the left atrial appendage and produced hemopericardium and tamponade. The patient was treated successfully.

CASE REPORT

A 55-year-old black female was in a college classroom when a natural gas explosion occurred at 1:05 P.M. on January 25, 1982. She arrived at the Cooper Hospital/University Medical Center emergency room at 1:15 P.M. without an obtainable blood pressure or palpable pulse. She was conscious but restless and tachypneic. Physical examination revealed dilated pupils, markedly distended neck veins, midsternal ecchymosis, and a closed fracture of the left forearm that was angulated. Heart sounds were rapid but distant. Endotracheal intubation and insertion of large bore peripheral and central lines were immediately done and 5 percent glucose in water was infused. A diagnosis of cardiac tamponade was made because of the findings of distended neck veins, unobtainable blood pressures, ecchymosis over the sternum, and distant heart sounds. Prompt pericardiocentesis was done and 20 cc of bright red blood was aspirated. The radial pulse immediately became palpable. A subxyphoid pericardiotomy then was performed. A large tube was inserted into the pericardium which drained an additional 200 ml of bright red blood. The bright red color of the blood and tamponade seemed to indicate intrapericardium bleeding most likely from the left atrium, left ventricle, or pulmonary veins.

The patient then was immediately transported to the operating room. At 1:30 P.M., a median sternotomy incision was made and a laceration of the left atrial appendage was repaired. Multiple rib fractures, a sternal fracture, and ecchymosis over the root of the aorta also were noted during the operation. Three days later, a tracheostomy was performed because the sternal and rib fractures inhibited adequate respiration. Later in the hospitalization, she had an open reduction of the forearm fracture and she was discharged on February 11, 1982.

The patient was readmitted on May 18, 1982, because of chest pain. Angina, unstable sternal fracture, and infection were ruled out by appropriate studies. An elevated sedimentation rate, low grade fever, and pericardial friction rub suggested postpericardiotomy syndrome. Symptoms subsided after treatment with aspirin and she was discharged on May 26, 1982.

DISCUSSION

Desforages, Ridder, and Lenoci reported the first suc-

cessful repair of cardiac rupture after nonpenetrating injury in 1955.⁵ Subsequent repairs of survivors of atrial rupture have been published.^{2,3,6-10,12-15} All these reports were of injuries inflicted by motor vehicle accidents. Our case is the first reported from a blast injury. Bright and Beck reviewed 168 cases of nonpenetrating injury to the heart.⁴ Three of these patients were injured by an explosion. In autopsy series of 346 patients who died of blunt cardiac trauma reported by Parmley, Manion, and Mattingly,¹¹ there were 67 cases of isolated atrial rupture. It was noted that 13 of the patients did not die immediately. Bright and Beck reported that 30 of 168 patients with atrial rupture survived longer than one hour after injury.⁴ The diagnosis of cardiac injury and initial treatment occurred within 15 minutes from the time of injury in our patient. Preliminary treatment with endotracheal intubation, insertion of a large bore catheter in a vein, pericardiocentesis, subxyphoid pericardiotomy using local anesthesia,¹ and rapid transport of the patient to the operating room for median sternotomy undoubtedly were responsible for her survival.

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HEMATOGENOUS OSTEOMYELITIS OF THE TARSAL NAVICULAR BONE

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Hematogenous osteomyelitis usually occurs in the skeletally immature person. A runner developed this problem in the tarsal navicular bone, but it mimicked tendinitis. Physicians should consider this diagnosis when apparent trauma or overuse syndromes fail to respond to therapy.

Hematogenous osteomyelitis occurs more frequently in the metaphyseal region of a tubular bone than in flat or irregular bones.⁸ Among the tarsal bones, the calcaneus most often is affected. Hematogenous osteomyelitis of the tarsal navicular is far less common: a careful review of the literature revealed only six cases mentioned in more than 20 years (Table). We will describe the problem of a college runner whose condition simulated tibialis anterior tendinitis.

CASE REPORT

A 19-year-old female college athlete experienced pain in the medial side of her left foot following consecutive quarter- and half-mile races. She was forced to refrain from running because of aching in her foot; redness and swelling extended up the inner aspect of the shin. She was treated with unknown dosages of phenylbutazone (Butazolidin®) for four days by a physician at the college health center and improved. The pain, swelling, and redness, however, recurred when the medication was stopped. Roentgenograms showed no evidence of stress fracture or soft tissue involvement (Figure 1). No other studies were obtained at that time. Again, she improved with elevation of her foot, no weight bearing, Butazolidin®, and codeine. Two weeks following the onset of symptoms, she suffered an exacerbation and was seen by an orthopedist who found erythema, swelling, and tenderness over the

dorsum of the foot. This process extended along the tibialis anterior tendon and was felt to represent chronic tendinitis. Butazolidin Alka® was prescribed (200 mg four times daily for three days and then one tablet daily for two days was given). The foot was elevated and weight bearing was not permitted. There was less erythema and swelling. Butazolidin Alka® (100 mg three times daily) was continued. Radiographs were unremarkable (Figures 2 and 3). No other studies were obtained.

Twenty-eight days following the onset of her symptoms she came to the emergency room of Monmouth Medical Center, Long Branch, because of pain, erythema, and edema of the entire left foot. Temperature was 98.5° F; erythrocyte sedimentation rate (ESR) was 95 mm/hr. White blood cell count was 11,400, 82% neutrophils, and 8% bands. Roentgenograms showed cortical destruction of the dorsum of the tarsal navicular (Figure 4).

Under fluoroscopic control, we aspirated a small amount of blood-tinged fluid from the bony defect using a large-bore needle. No organisms were found on Gram's stain but cefazolin (Ancef®) was administered in a dosage of 1 gm intravenously every six hours.

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Figure 1—Initial radiographs.



Figure 2—Radiograph taken two weeks after onset of symptoms.

Culture of the aspirate was positive for *Staphylococcus aureus* which was sensitive to nafcillin. The cefazolin was discontinued and nafcillin in a dosage of 1 gm was administered every four hours. Serum cidal titers were 1:32 and 1:64 on two occasions. Bone scan and gallium scan showed increased uptake in the left tarsal navicular bones (Figures 5 and 6).

The patient was much improved within 48 hours. The white blood cell count returned to normal (5,400, 47% neutrophils, 4% bands). ESR remained elevated for 10 days, then remained between 32 to 38 mm/hr

TABLE

Authors	Navicular Involvement	Cases in Series
Donovan and Shah, 1982	1	16
Mollan and Piggot, 1977	0	93
Morrey, Bianco, and Rhodes, 1978	0	145
Morrey and Peterson, 1975	0	135
Nixon, 1978	1	164
Roberts, 1982	2	55
Trueta, 1959	0	202
Waldvogel, Medoff, and Schwartz, 1970	0	247
Winters and Cohen, 1960	2	72

until the patient was discharged. Because multiple areas of phlebitis secondary to nafcillin developed, oxacillin (1.5 gm intravenously every four hours) was substituted and continued for 28 days. For the first three weeks, her foot was kept elevated and in a posterior splint with the ankle maintained at 90° of dorsiflexion. She received one week of physical therapy and resumed training two weeks after discharge.

Radiographs of the left foot, taken one month following discharge, showed healing of one cortical defect and spontaneous fusion of the navicular to the talus (Figure 7). Six weeks following therapy the gallium scan showed diminished activity compared to the previous study (Figure 8). The white blood cell count was 4,200 with 50% segmented, 1% bands, 45% lymphs, 2% monos, and 2% eosinophils. The erythrocyte sedimentation rate was 20 min/hr.

DISCUSSION

Hematogenous osteomyelitis is rare in adults and more commonly occurs in one metaphysis of the skeletally immature person. Trueta's explanation of the pathogenesis of hematogenous osteomyelitis concerns the vasculature adjacent to the growth plate and the metabolic activity of one rapidly growing bone.¹⁰ Also, the small capillary ramifications of the nutrient artery supplying the metaphysis, which are 8μ in size, have been shown to make sharp loops before turning at the growth plate to enter the larger (15 to 60μ) sinusoidal veins which have slower and more turbulent blood flow. In addition, the arteriolar vessel is a true capillary membrane and lacks phagocytic lining cells.

Lastly, the capillary loops adjacent to the metaphysis are nonanastomosing branches of the nutrient artery which are end arterioles. Their occlusion results in small areas of avascular necrosis.^{6,11}

A further explanation is given by Nixon who considers the subchondral area of flat and irregular bones comparable to the area under the growth plate at a tubular bone as "metaphyseal-equivalent locations."⁸ This would include areas adjacent to apophyseal growth plates, articular cartilage, or fibrocartilage although it is recognized that this definition is not strictly accurate anatomically. It seems that the same mechanism producing hematogenous osteomyelitis in long bones would apply to these metaphyseal equivalent regions.

Trauma often precipitates hematogenous osteomyelitis.² Watson and Whitesides have reported five cases of hematogenous osteomyelitis complicating



Figure 3—Radiograph taken two weeks after onset of symptoms.



Figure 4—Radiographs showing cortical destruction of the dorsum of the tarsal navicular (arrow).



Figure 5—Bone scan showing increased uptake in the left tarsal navicular.

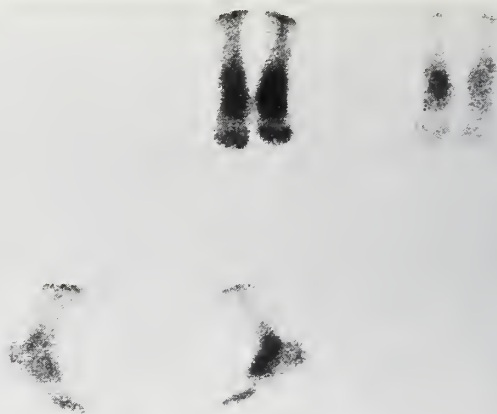


Figure 6—Gallium scan showing increased uptake in the left tarsal navicular.



Figure 7—Radiograph six weeks following onset of symptoms showing healing of the cortical defect and fusion of the navicular to the talus.



Figure 8—Gallium scan showing decreased uptake compared to the study done six weeks earlier (Figure 6).

closed fractures.¹² Hedstrom and Lidgren suggest that hematogenous osteomyelitis should be regarded as a local manifestation of bacteremia or septicemia. They reported three cases of pelvic osteomyelitis in athletes with traumatic and overuse injury, with positive blood cultures obtained in two of them.³ Most sources report positive blood cultures in 50 percent of patients with hematogenous osteomyelitis.^{11,12}

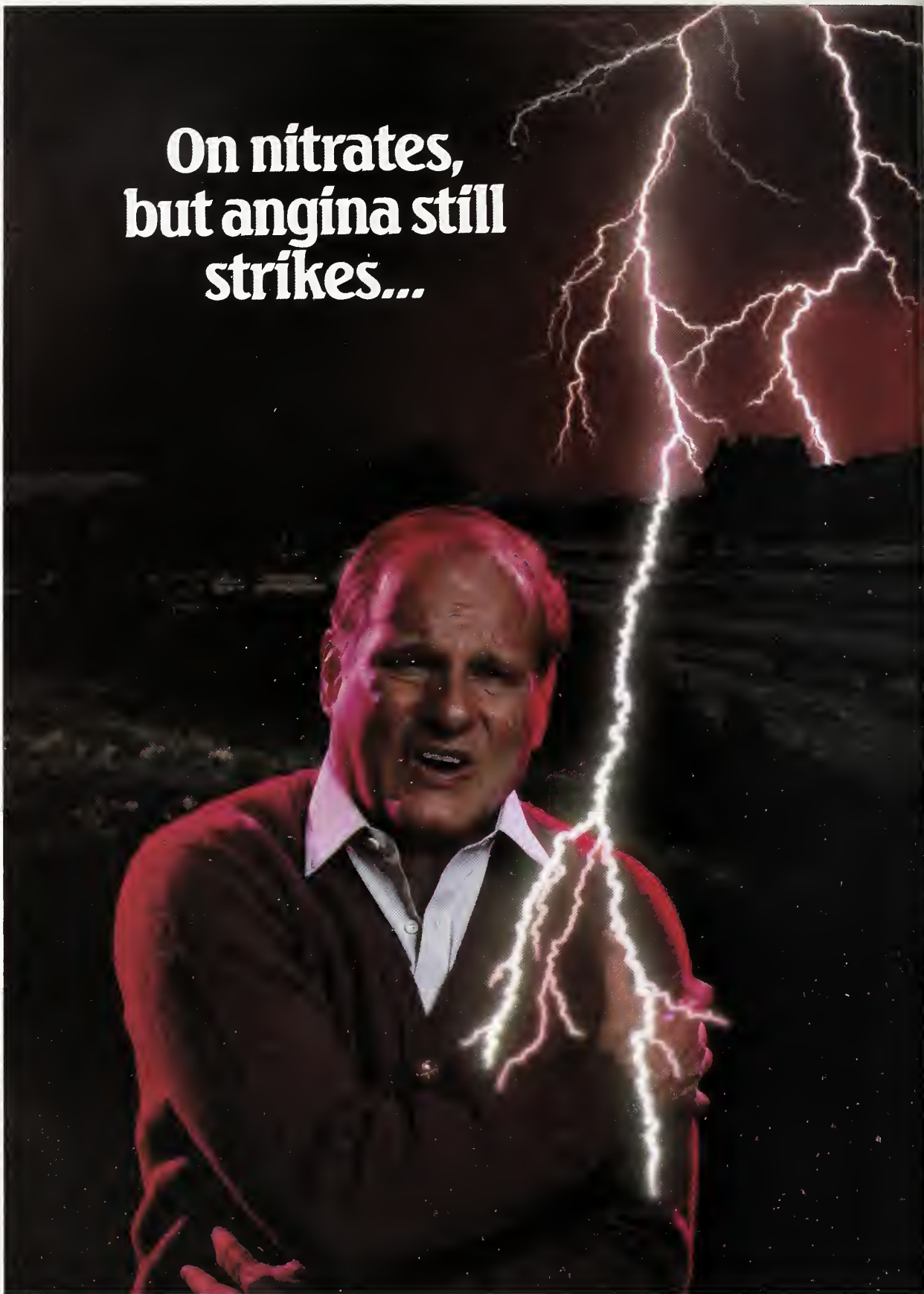
CONCLUSION

Our patient represents an example of trauma implicit in the activity of running which resulted in seeding of a locus minoris resistentiae during a transient bacteremia. This was believed to be tendinitis by several physicians. Physicians should be suspicious of apparent trauma or overuse syndromes that fail to respond to the usual therapy in a reasonable period of time. Further studies including nuclear scanning, bacterial cultures, aspiration, and biopsy of suspected site are essential.

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The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385



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PREOPERATIVE ANGIOGRAPHIC ASSESSMENT OF SAPHENOUS VEIN FOR ARTERIAL BYPASS SURGERY

GARRY D. RUBEN, M.D., SCOT E. GOLDBERG, D.O., CONSTANTIN COPE, M.D.,
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Preoperative saphenous venography agreed with surgical evaluation in 40 of 52 veins in patients undergoing lower extremity vascular reconstruction. Preoperative saphenous venography is a useful technique for delineating disease and adequacy of the saphenous vein.

Early in the development of arterial bypass surgery of the lower extremities, it was recognized that the autologous saphenous vein was the optimal graft material and the standard by which other grafts would be judged.¹⁻³ Although most patients requiring reconstructive procedures have a usable saphenous vein, some veins are diseased or of inadequate diameter.⁴ Other patients will have had previous vascular surgery leaving the status of the vein in doubt.^{2,5} Although preoperative clinical assessment of the saphenous vein may yield useful data in as many as half of all patients,⁵ the vein commonly is evaluated at surgery. When the vein is found unsuitable, valuable time is wasted and the operative course may be altered or abandoned.⁴ Accurate preoperative assessment of the vein with respect to diameter, length, and disease significantly could improve operative planning and avoid unnecessary dissection. In patients in whom surgery depends upon use of a vein, the knowledge of vein morphology may obviate the need for unnecessary incisions and surgery according to Veith.⁴

MATERIALS AND METHODS

From July 1, 1981, to December 31, 1983, 68 patients underwent a vascular reconstructive procedure on the lower extremity. Forty-three of these patients underwent preoperative saphenous venography. Bilateral examination was performed on 40 patients

making a total of 83 extremities studied. Fifty-two veins were examined at surgery. There were 27 men and 16 women. The average age of patients undergoing venography was 65.6 years with a range of 24 to 92 years. Twenty-five patients were excluded from venography because they had: 1) a clinically usable vein; 2) readily apparent disease, e.g. significant varicosities; or 3) use of their veins for prior operative procedures. If the vein was found radiographically to be 2.5 mm or less in diameter, to have significant varicosities, or was not visualized, it was considered to be unsatisfactory for use as a revised autologous graft. The length of usable vein was related to the planned procedure in assessing its adequacy. Intraoperatively, a vein was considered adequate if it was at least 3 mm in internal diameter either at first inspection or after dilatation with heparinized saline.

All patients had arteriosclerotic obstructive disease of the lower extremities. The indications for surgery were: rest pain in 22, gangrene or ischemic ulcers in 18, and disabling claudication in 11.

Saphenous venography was performed with the patient placed on a long angiographic table in the supine position. The dorsum of the foot is cleansed with providine iodine and a 21-gauge scalp vein needle is

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TABLE
Operations

Procedure	Total	Ipsilateral saphenous vein	Contralateral saphenous vein	PTFE	Umbilical vein	Cephalic vein
Femoropopliteal artery bypass—above knee	17	4	2	10		1
Femoropopliteal artery bypass—below knee	17	8	1	3	4	1
Femoral anterior tibial artery bypass	3	1			2	
Femoral posterior tibial artery bypass	3				1	2
Sequential bypass	7	5*		4*	1	2
Popliteal posterior tibial artery bypass	3	1	2			
Femoral peroneal artery bypass (in situ)	1	1				
Total	51	20	5	17	8	6

*Three (3) cases Gortex femoropopliteal and vein femorotibial.

introduced into a branch of the saphenous vein and is connected to an intravenous solution of 5 percent dextrose. An automatic injector is used to deliver 40 ml of contrast (Conray® 60) per leg at a rate of 1 ml per second. An Automatic Rapid Transport film changer and a Phillips 28-inch long leg cassette film are used. No tourniquets are applied. Two exposures (14 x 28) are made from the ankle to the mid thigh, and another two from the knee to the pelvis. Following the procedure, the intravenous solution is infused to flush the contrast from the vein.

RESULTS

Of the 52 veins examined at surgery, the preoperative venographic interpretation was confirmed in 40 limbs. There was negative correlation between venographic interpretation and surgical findings in the remaining 12. In 26 extremities, venographic demonstration of an unusable vein was confirmed at the time of surgery. Of these 26, 21 were inadequate because they were too small. Twelve measured from 2 to 2.5 mm on x-ray; 9 measured less than 2 mm. The others were unusable because of disease in either the deep or superficial systems. In an additional 14 limbs, surgery confirmed the venographic interpretation of a usable vein. Seven venograms showed apparently inadequate veins which, at the time of surgery, were either of adequate caliber upon initial inspection or were dilated easily to an acceptable diameter. Of these 7 venograms, 3 were adequate radiographically for an above-knee popliteal anastomosis while below-knee the vein measured 2 to 2.5 mm on x-ray. The distal portion was dilated at surgery to greater than 3 mm and the vein used for a below-knee popliteal anastomosis. Two veins measured 2 to 2.5 mm and 2 veins measured 1 mm on x-ray through most of their length and were preoperatively interpreted as too small. At surgery, these veins were dilated to an adequate diameter and

used. In five venograms where the veins were read as adequate (2.5 mm or greater), the veins were found to be too small at surgery for use. One vein, that appeared suitable both radiographically and when exposed and harvested at surgery, exhibited significant segmental narrowing after insertion as a graft. These narrowed areas could not be dilated and were bypassed with an umbilical vein graft. One vein, considered to be too small radiographically for use as reversed saphenous graft, prompted planning for an in situ procedure. The venographic interpretation was confirmed at surgery and a successful in situ femoral to peroneal artery bypass was accomplished.

Valuable information regarding the deep venous system was obtained in two patients. One patient had active deep venous thrombosis at the time of venography and required anticoagulation therapy prior to surgery. In the other, the saphenous vein was the only outflow due to apparent absence of the deep system.

Saphenous veins from the opposite leg were used in four cases based upon the preoperative venogram. These represented situations in which the vein in the operated leg had been previously removed, was too small, or was diseased. In three patients, the saphenous vein in the operative area was found to be too small. However, venography demonstrated a suitable vein in a different part of the extremity. These observations were confirmed at surgery. Significant varicosities, not seen on clinical examination, were diagnosed venographically and confirmed at surgery in three patients. In three patients, a vein was not visualized on x-ray and at surgery inadequate veins were found.

In two cases, the preoperative plans for femoral posterior tibial artery bypass were altered to sequential bypass on the basis of the venogram. In these cases, the venogram showed only a short usable segment. The operative findings were consistent with the venogram.

In each case, polytetrafluoroethylene (PTFE) was used for the femoropopliteal portion of the bypass and the segment of saphenous vein was used for the popliteal tibial segment.

In 23 patients, where the vein appeared unsuitable in the limb undergoing reconstruction, an alternate vein or graft material was used. The source of alternate vein was either saphenous vein from a part of the ipsilateral leg outside of the arterial exposure, saphenous vein from the contralateral extremity or a cephalic vein. In one case, a planned below-knee femoropopliteal artery bypass was changed to above-knee and PTFE was used. With the exception of two sequential bypasses noted above, all procedures were completed as planned except for changes in graft material. Cephalic venograms were carried out in 17 patients when the saphenous vein was seen to be unsuitable. In 6 patients, the cephalic vein was used.

There were 51 operations on 50 limbs (Table). Twenty-five saphenous vein grafts (including 1 in situ graft), 17 PTFE grafts (3 in conjunction with saphenous vein), 6 cephalic vein grafts (1 in conjunction with saphenous vein), and 8 umbilical vein grafts were employed.

One patient died on the fifth postoperative day of a pulmonary embolus. This patient had a normal preoperative venogram. One patient, with a good saphenous vein by x-ray, was found to have a thickened saphenous vein containing clot at surgery.

DISCUSSION

If operative decisions were based upon venography, over half of the patients would have had operative time reduced by not searching for and exposing a small or diseased vein. Useful information about unsatisfactory veins was found in 26 of 51 operations. This helped to better plan the surgery either by preparing an alternate site for vein harvest, utilization of nonautologous graft material, or modification of the planned procedure to use the in situ technique. Veith et al. found that in patients routinely studied by venography, 30 percent were shown to have abnormalities that significantly influenced management of the patient.⁴ Although he suggested that surgery even may be avoided in some patients, all of our patients underwent reconstruction using nonautologous graft when necessary. Whereas other investigators^{4,6} found no instances where a vein, which was suitable by phlebogram, was unsatisfactory at surgery we noted this in 5 instances. More significant in our series were the 7 patients who had inadequate veins by phlebography which were usable at surgery. The apparently inadequate portions were able to be dilated to acceptable diameters. If operative decisions had been based entirely on venographic findings, these veins would not have been used.

In those patients where an autologous vein was felt to be vital to reconstruction, the venogram was useful for locating a satisfactory vein outside the field of reconstructive surgery. Information on the deep venous system allowed us to avoid operating on one patient with active deep venous thrombosis and from harvesting the sole venous outflow tract in the limb of another.

Bettman and Paulin reported a contrast-related in-

flammatory response in the veins of their patients occurring at about 24 hours after phlebography.⁷ The two complications noted in this study (one patient with clot in the saphenous vein and another patient with a documented pulmonary embolus) may have been secondary to such a dye reaction.

All elective surgery was delayed at least 24 hours after venography to assess renal function after dye injection. There were no dye-related renal problems noted in these patients.

We conclude that saphenous venography is an effective means of delineating disease or demonstrating disease or demonstrating adequacy of the saphenous vein in most cases. This allows better preoperative planning and may result in decreased operative time. The procedure specifically is indicated in patients with a history of phlebitis, those in whom harvest of a vein from the opposite limb is being considered, or in whom an in situ bypass is planned. While most veins 2 to 2.5 mm in diameter radiographically proved unsuitable at surgery, five veins were able to be dilated sufficiently for use. It would seem reasonable, therefore, to examine veins measuring 2 to 2.5 mm in diameter radiographically for possible use as a reversed graft. Veins less than 2 mm in diameter on x-ray are unlikely to be used successfully as a reversed graft. In the patient in whom a saphenous vein is deemed absolutely necessary for reconstruction, however, venographic demonstration of vessels of inadequate diameter should not preclude surgical evaluation of those veins. Although the possible occurrence of deep venous thrombophlebitis or superficial phlebitis as a result of this procedure must be considered, the benefits outweigh the risk.

SUMMARY

Forty-three underwent preoperative saphenous venography. Venographic results were substantiated in 40 of 52 cases. In 7 patients, veins judged unsatisfactory roentgenographically were found to be usable at surgery. Preoperative saphenous venography is an effective adjunct in the preparation of a patient for vascular reconstruction of the lower extremities. It is useful in evaluating the location and extent of usable vein for bypass and for ruling out concurrent disorders of the venous system. Surgical exploration of the vein is indicated even in the face of a venogram showing a small vein if vein graft is considered vital.

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INTRODUCTION OF *SALMONELLA TYPHI* IN THE UNITED STATES VIA TRAVELERS

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Diagnosis of typhoid fever in two children was made by clinical appearance, "picket fence" fever curve, and positive blood and stool cultures. Physicians should consider this diagnosis in patients who develop a compatible syndrome after travel to foreign countries, especially India and Mexico.

A *Salmonella typhi* infection (typhoid fever) always has been potentially dangerous and has been viewed as a serious public health problem. Two children developed *S. typhi* after a trip to India.

CASE REPORT

Two siblings visited India for five weeks. The older, a seven-year-old male, developed fever and diarrhea just prior to his return to the United States. He recovered, but five weeks later he developed fever, anorexia, and diarrhea, and lost 12 pounds. On admission to the Cooper Hospital/University Medical Center, his weight was 45½ pounds; temperature, 102.5°; pulse, 124; and respirations, 24. Generalized abdominal tenderness was elicited. He had a "picket fence" fever curve for 4 days. Extensive laboratory studies were normal or negative until *S. typhi* was recovered from the blood and stool. He was treated with 500 mg of chloramphenicol, intravenously every six hours for 3 days. The organism was sensitive to a number of antibiotics, including ampicillin and chloramphenicol. Therapy was changed to 500 mg of ampicillin, intravenously every six hours for 14 days. At the time of discharge, the patient was well although the stool culture still was positive for *S. typhi*, and the blood culture was negative. Ampicillin was continued in a dose of 500 mg, orally every six hours for 7 days after discharge. Two months after discharge, stool cultures were negative for *S. typhi*.

The five-year-old sibling was ostensibly well while in India. Six weeks after his return to the United States he developed fever, diarrhea, and vomiting. A *S. typhi* infection was considered because of his brother's illness. On admission to the Cooper Hospital/University Medical Center, his weight was 33 pounds; temperature, 105°; pulse, 130; and respirations, 22. His abdomen was tender. *S. typhi* was recovered in cultures from the blood and stool. The organism was sensitive to a number of antibiotics, including ampicillin and chloramphenicol. Initial treatment was 375 mg chloramphenicol, intravenously every six hours for 2 days and then was changed to 750 mg ampicillin, intravenously every six hours for 3 days. Diarrhea and fever continued, so ampicillin was stopped and chloramphenicol in the original dose was administered. He made an uneventful recovery, but his stools were positive for *S. typhi* at the time of discharge. Following discharge, he was given 500 mg ampicillin, orally every six hours for one week. Three and one-half weeks later, he developed fever and diarrhea. Cultures from the blood and stool revealed *S. typhi*, and he was hospitalized again. The patient was treated with 300 mg chloramphenicol, intravenously every six

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hours for 14 days. He made a complete clinical recovery. At the time of discharge, the blood culture was negative. The stool culture was positive for *S. typhi*, but cultures were negative two months later.

The father who accompanied the children to India, had negative stool cultures. The mother, who lived elsewhere, visited the children periodically and her stool cultures were negative. The children were in school until they developed symptoms and then were excluded until the stool cultures became negative. Obvious secondary cases did not develop in any child at the school.

DISCUSSION

There are over 1,800 different *Salmonella* serotypes, however, 20 are responsible for most cases of salmonellosis.¹ Some serotypes, such as *S. choleraesuis*, *S. typhimurium*, and *S. typhi*, generally are more virulent than others. The overall hospital case fatality rate for typhoid fever in Asia and Africa has been reported between 12 and 32 percent.² However, others state that the case fatality rate has been less than 2 percent since the introduction of chloramphenicol.³ The mortality in children relates to a number of factors, such as the severity of disease. Galloway et al. reported a mortality rate of 4 percent, but very few of his patients were seriously ill.⁴ Scragg et al. reported a mortality rate of 25 percent, but 50 percent of his patients were quite ill.⁵

S. typhi is a strict human parasite; the ultimate source of the organism usually is traced to a human. The organism generally is excreted in feces or urine from a patient with typhoid fever or a carrier. Contaminated water and/or food are the principal vehicles of spread. It generally requires 10^7 organisms to infect an individual. Hypochlorhydria predisposes to bacterial colonization, while hyperchlorhydria inhibits bacterial growth.⁶ Organisms pass into the lymphatics and mesenteric nodes where they multiply and then spread into the blood stream to produce transient bacteremia. From there, the organisms disseminate to the liver, spleen, and other reticuloendothelial tissues. Organisms re-enter the blood stream in huge numbers, and this heralds the onset of the clinical illness. During the second bacteremic phase, the organisms almost always invade the gallbladder.

The clinical manifestations of typhoid fever in children frequently are atypical.^{5,7} Findings include fever, diarrhea, and respiratory symptoms. Convulsions are common below the age of three. Relative bradycardia, leukopenia, and rose spots, which are important findings in adults, usually are absent in children. Splenomegaly is infrequent. Morbidity is significant. The condition is associated with a number of potentially dangerous complications: intestinal hemorrhage, intestinal perforation, neuropsychiatric confusion, encephalopathy, focal epilepsy, isolated cranial nerve involvement, polyneuropathy, subclinical disseminated intravascular coagulation, immune complex glomerulonephritis, anemia, hemolytic-uremic syndrome, pneumonia, hepatitis, pancreatitis, infections in bone and spleen, and toxic myocarditis.⁸

The diagnosis may be established by cultures of blood, stool, and bone marrow. The presence of rose spots and the Widal reaction are helpful. Blood culture

is positive in approximately 80 percent of cases. The frequency of positive cultures decreases with time. Isolation of the organism in the third week is possible. Stool cultures may be positive in the first week, but the incidence of positive cultures increases during the second and third weeks. Positive cultures are found in 90 percent of bone marrow aspirates and 60 percent of patients with rose spots.⁹ The Widal reaction suggests *S. typhi* infection in nonimmunized individuals when the O titer is 1:80 in nonendemic regions and 1:160 in endemic areas. A rising titer is of greater diagnostic significance. The O antibody appears first but disappears in a few months. The H antibody develops later and persists for a long time. The O antibody generally indicates an active infection, while the H antibody is used to identify the type of enteric infection. Finally, the Vi antibody does appear in some patients who have an active infection. There are some limitations to the Widal reaction in that a rising O antibody titer may be due to a different serotype that shares a common O antigen. And, in some endemic areas, patients have a high H antibody titer from constant exposure.

"Rapid diagnosis is the best technique to control the spread of infection."

Chloramphenicol, ampicillin, and trimethoprim sulfamethoxazole are the most common antibiotics used in *S. typhi* infections.¹⁰ Chloramphenicol generally is considered the drug of choice, although the emergence of resistant strains has led to the consideration of other antibiotics. The siblings presented in this paper received chloramphenicol and ampicillin. The five-year-old patient had a documented relapse, which is a common occurrence in *S. typhi* infections. Eventually, the children were cured of their infections, but both were carriers for two months. The carrier state is related to the entrenchment of the organism in the gallbladder, which is thought to be far less frequent in children than adults. In most individuals the organism disappears within three months; however, in adults there is a 3 percent carrier state at the end of one year. Antibiotics have not eradicated the carrier state; however, cholecystectomy has had some limited success.

In the United States, there have been approximately 350 to 600 reported cases of typhoid fever per year since 1965.¹¹ Large outbreaks occurred in Florida in 1973 and in Texas in 1981 and 1982. The majority of cases in the United States are introduced from overseas, especially from Mexico and India where the contributions to reported cases are 50 and 15 percent, respectively. While in India, the seven-year-old patient had a brief illness that probably was typhoid fever, and he suffered a relapse after arrival in the United States. The incubation period, 3 to 56 days, would indicate that the five-year-old patient could have acquired the disease in India or in the United States. Clinical symptoms first developed in the seven-year-old patient, but his diarrhea was similar to that seen in enteritis caused by other enteric pathogens. The "picket fence"

fever curve was the only clue that suggested the diagnosis of typhoid fever. Such a patient is a medical threat to household contacts and the public until the diagnosis is established. After the diagnosis was made, the necessary steps were taken to protect the public, i.e. isolation of the children from the community-at-large, especially the school populations.

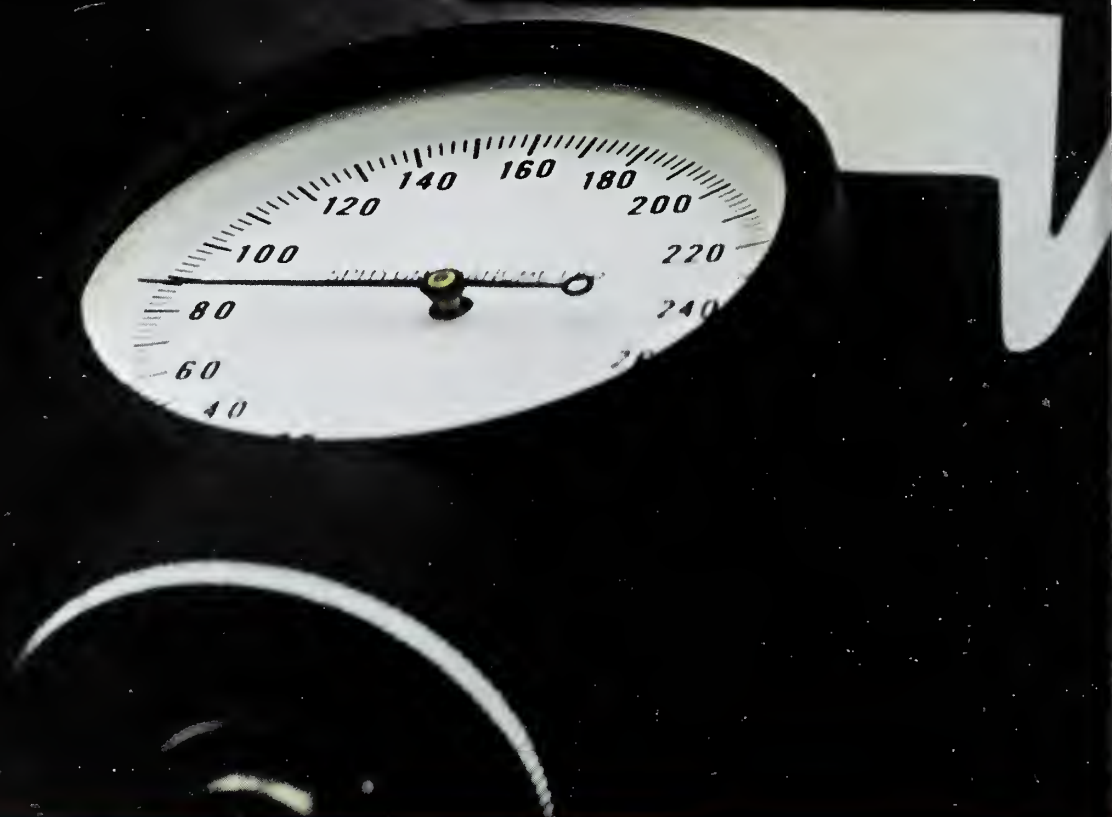
CONCLUSION

Air transportation has produced unparalleled interdigitation of countries and populations around the world. This has caused concern about the transmission of serious contagious diseases into the United States. Great care was taken to protect individuals in the United States against importation of smallpox. Similar concern should be extended to typhoid fever, a potentially dangerous contagious disease. Transmission of *S. typhi* from carriers is considered rare in the United States because the carrier state is thought to be uncommon in this country. Typhoid fever develops de novo in the United States primarily through contact with a patient who has an active infection. The majority of patients with active disease will be travelers from foreign countries. Because of this, we should consider the diagnosis of typhoid fever in individuals who develop diarrhea while traveling in countries where typhoid fever is prevalent. Rapid diagnosis prompted by a high index of suspicion is the best technique available to control the spread of the infection in households and the community.

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CASE REPORT: GIANT BENIGN PLEURAL FIBROMA WITH SYSTEMIC ARTERIOVENOUS SHUNTING

A.D. CARILLI, M.D., J. LIN, M.D., M. WAHBA, M.D., J. BITSACK, M.D., R. NEVILLE, M.D., NEWARK*

We report a case of giant benign pleural fibroma of over 40 years' duration. Clinical, physiologic, and roentgenographic evidence of systemic arteriovenous shunting was noted. Massive uncontrollable intrathoracic hemorrhage occurred following resection.

Primary pleural tumors occur in diffuse and localized forms. The diffuse form arises from the mesothelium and is known as diffuse malignant mesothelioma. The localized form is known by a variety of names which include benign fibrosing mesothelioma, localized pleural fibroma, and localized mesothelioma.¹ Its origin still is not well elucidated.

We report a case of benign giant pleural fibroma of more than 40 years' duration. Unusual clinical features and physiologic and arteriographic evidence of systemic arteriovenous shunting were striking. Massive uncontrollable intrathoracic hemorrhage occurred five weeks after surgery and three weeks following discharge from the hospital.

CASE REPORT

A 77-year old white male was admitted to Hackensack Medical Center because of increasing dyspnea. Over the six months prior to admission, dyspnea on exertion, mild orthopnea, and dry cough were experienced. This was accompanied by a 15-pound weight loss, severe generalized weakness, and easy fatigability. A routine chest film in 1939 showed a benign-looking, coin-sized lesion in his right lower lung according to the history. He sought no further medical attention until his present complaints. A nonsmoker, he worked as a shipping clerk, with no exposure to asbestos. Physical examination revealed a

thin, white male who was slightly dyspneic at rest. Blood pressure was 160/80 and pulse was 100. The lower anterior surface of the right hemithorax revealed a group of large dilated veins having the appearance of a caput medusae. A loud bruit was heard over the right sixth intercostal space, the center of this venous pattern.

The lower two-thirds of the chest was dull to percussion with absent breath sounds. The heart examination was not remarkable. There was no evidence of clubbing. The hemoglobin was 11 gm/dl and hematocrit 31%. The white blood cell count was 10,500/mm³. Pulmonary function tests revealed a vital capacity of 1.78 L (55.6% predicted). The FEV₁ was 0.96 L and FEV₁/FVC 53%. The Pao₂ was 60 mm/Hg, Paco₂, 44 mm/Hg, and pH, 7.48. The chest film showed a large opacity occupying the lower two-thirds of the right hemithorax (Figure 1). Large irregular calcifications were present in the mass adjacent to the seventh, eighth, and ninth ribs anteriorly. There was evidence of pressure erosion of the seventh rib anteriorly.

Computerized tomography confirmed the presence

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Figure 1—Chest film showing a large opacity with irregular calcification occupying the lower two-thirds of the right hemithorax.



Figure 2—Thoracic arteriogram showing the markedly hypertrophied right internal mammary arteries and the highly vascular nature of the lesion.

of the large mass which displaced the mediastinum and the heart to the left. Arteriogram of thoracic and upper abdominal vessels was performed. The mass separated into an anterior and posterior component. The posterior component received its vascular supply from the posterior intercostal arteries. The larger anterior component received its blood supply predominantly from a hypertrophied internal mammary artery and an enlarged anterior mediastinal artery. Multiple tumor vessels are noted throughout with suggestion of small capillary arteriovenous shunting (Figure 2). Right heart catheterization revealed normal pressure readings from right atrium to pulmonary artery. Oxygen saturation at different levels was as follows: superior vena cava 87%, inferior vena cava 80%, right atrium 81%, right ventricle 77%, and pulmonary artery 74%. The cardiac index was 5.75 L/min/mm.¹ Pulmonary arteriography showed no evidence of pulmonary arteriovenous malformation or blood supply to the tumor from pulmonary arteries.

At thoracotomy, a large, well-encapsulated bilobular fleshy tumor was found. The tumor arose from the parietal pleural, receiving a large portion of its blood supply from the right internal mammary artery, and fifth, sixth, and seventh intercostal arteries. The tumor was adherent to the mediastinal and diaphragmatic pleura. There appeared to be tumor invasion only on the anterior seventh rib. Following removal there was good expansion of the lung in the right hemithorax. The tumor weighed about 2.8 kg and measured 19 x

17 x 8 cm (Figure 3). On sectioning, the surfaces were tan-yellow, hyperemic, and gelatinous. A 5 cm calcified area was noted. The lesion consisted of proliferating fibroblasts arranged in a dense and loose pattern, interspersed with some dense connective tissue. Myxomatous degeneration was present. There were numerous small vessels, some of which appeared to communicate with one another (Figure 4).

The patient recovered from this surgery and was discharged in two weeks. Three weeks later, he was readmitted with marked dyspnea. His hemoglobin was 5.9 gm/dl and hematocrit 17.6%. The chest films revealed a large right pleural effusion. A chest tube was inserted and 2,100 ml of blood was drained initially. Over the next six days, he continued to drain large amounts of blood. An exploratory thoracotomy was performed. Generalized oozing from the parietal pleura was noted. Postoperatively, he continued to bleed and finally succumbed to massive hemorrhage and renal failure a week later.

DISCUSSION

Localized mesothelioma of the pleura was first described by Wagner in 1870.² In 1931, Klemperer and Rubin classified primary pleural fibromas as localized and diffuse and advocated that the diffuse form arose from mesothelial cells, but the localized form arose from submesothelial connective tissue³. Later, more evidence derived from tissue culture and electron microscopy has supported the view that the localized

form also arose from cells that were of mesothelial character. The term fibrous mesothelioma has been used widely,^{4,5} but the histogenesis of these tumors still remains controversial since other work has shown that submesothelial multipotential fibroblasts may differentiate into mesothelial cells. Therefore, benign and malignant pleural tumors may both arise from these submesothelial connective tissue cells.⁶ Localized pleural fibromas are rare, the incidence being 2.8 cases per 100,000 registrations at Mayo Clinic.² The tumors vary greatly in appearance. The majority arise from visceral pleura, but some may be entirely intrapulmonary with pleura contract at some point. Occasionally, the tumor may be mobile on its pedicle.⁷ Most reports indicate that malignancy is rare in localized tumors which project into the pleural cavity. However, the potential for malignancy is not clearly known since recurrences and metastases do occur many years after the initial excision.^{1,2}

Three major pathologic growth patterns exist: collagenized, hemangiopericytoma-like, and cellular. Many tumors show a mixture of these patterns. Myx-

omatous, chondromatous, and lipomatous changes may be found. Areas may be highly vascular and hemorrhagic with arteriovenous communications occurring as noted in the present case. More commonly, the tumors are avascular with calcification occurring in hyaline connective tissue.^{1,8}

Clinically, pleural fibroma may grow silently for many years. They rarely assume massive proportions causing cough and dyspnea by compression of the lung parenchyma and displacement of the mediastinal structures. The latter also may produce symptoms by impairing venous return. Our patient probably had his tumor for more than 40 years and developed symptoms only six months prior to resection. The tumors most commonly are detected in the fifth decade. Osteoarthopathy and clubbed digits occur frequently. Fever, hemorrhagic pleural effusion, and hypoglycemia also are described. There is no relationship to asbestos exposure.^{9,10}

Apart from its massive size, other unusual features of this case were the presence of a vascular pattern and bruit on the chest wall over the tumor, the finding of the markedly hypertrophied internal mammary, anterior mediastinal and intercostal arteries feeding the tumor, and the presence of systemic arteriovenous shunting. The findings of a significant step-up in oxygen saturation at the superior vena cava level and the high cardiac index were consistent with a highly vascular tumor containing small arteriovenous communications resulting in significant shunting.

As a final note of caution, these large solitary tumors arise from a narrow pedicle attached to the pleura, deriving a rich blood supply from many feeding vessels in the pleura. We cannot explain the delay in detecting the massive bleeding into the pleural cavity three weeks after discharge. There was no autopsy. We postulate that on removal of the tumor in our patient the rich vascular bed was most likely the source of the slow oozing which ultimately contributed to his demise.

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Figure 3—Gross appearance of the large encapsulated lobular pleural fibroma.



Figure 4—Microscopic appearance of tumor. Note the numerous small vessels appearing to communicate with one another.

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CASE REPORT: *STREPTOCOCCUS BOVIS* ENDOCARDITIS AND BOWEL NEOPLASM

JEREMIAS L. MURILLO, M.D., RUBY BENDERSKY, M.D., JULES A. TITELBAUM, M.D., NEWARK*

The association of Streptococcus bovis endocarditis with bowel neoplasm has been described. When this organism is identified as the pathogen in bacteremia or endocarditis, a complete evaluation of the gastrointestinal tract and a thorough search for a bowel neoplasm is indicated.

Streptococcus *bovis* has been recognized as an important pathogen in infective endocarditis.¹ The incidence of this infection appears to be increasing. Its importance has been enhanced by observations indicating its relationship with colorectal disease.

CASE REPORT

In January 1984, a 58-year-old white male developed fever, chills, nausea, and vomiting. His physician examined him and prescribed erythromycin, but after one week of therapy, only slight improvement was noted. A new heart murmur was detected so the patient was hospitalized. Aortic regurgitation followed by progressive congestive heart failure led to aortic valve replacement.

The patient was alert but mildly short of breath. Examination of the skin, head, eyes, ears, nose, throat, and extremities was unremarkable. The neck was supple and there was no lymphadenopathy. Auscultation of the chest revealed rales bilaterally at the lung bases. Examination of the heart revealed a grade 3/6 systolic ejection murmur at the second left intercostal space radiating to the carotids, subclavians, and axilla and a grade 2/6 early diastolic murmur at the apex radiating to the axilla. The abdomen was soft and nontender except for mild hepatic tenderness to deep palpation.

Laboratory data showed: Hgb 12.9 gm/dL, Hct 38.6%, WBC 10.2 cells/mm³ with 75% segs, 1% band, 17% lymphs, and 7% monos. Blood chemistries where: Na 134 mEq/L, K 4.6 mEq/L, CO₂ 27 nM/L, Cl 96 mEq/L, glucose 211 mg/dL, BUN 21 mg/dL, Cr 1.8 mg/dL, SGOT 27/ml, and SGPT 15 U/ml. Blood cultures grew *Streptococcus bovis* that was very sensitive to penicillin G.

The patient was treated with three million units of aqueous penicillin G intravenously every four hours. He received two weeks of antibiotic therapy prior to surgery and completed four additional weeks of treatment postoperatively. An echocardiogram revealed vegetations on the aortic valve and cardiac catheterization confirmed aortic regurgitation. Surgical exploration revealed a tricuspid aortic valve with incomplete fusion of the right and left cusps and large vegetations of the valve cusps. A large aneurysm of the right sinus of Valsalva with abscess formation was noted and was repaired without difficulty. The aortic valve was replaced with a 21 mm St. Jude prosthesis.

The patient did well postoperatively. An evaluation of the gastrointestinal tract including a barium enema

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and colonoscopy were performed because he persistently had guaiac positive stools. A villous adenoma was found in the colon at the hepatic flexure. He underwent a right colectomy without complications and was discharged on hospital day 37.

DISCUSSION

Streptococcus bovis is a nonenterococcal group D streptococcus that may produce either alpha hemolysis or nonhemolysis on blood agar plates. The organism reacts positively to bile esculin medium but is differentiated from group D enterococcus by its inability to grow in 6.5% NaCl. This organism should be differentiated from enterococcus because of the increased susceptibility of *S. bovis* to penicillin compared to enterococci. *S. bovis* has become increasingly important in recent years and its frequency in causing infective endocarditis appears to be increasing.¹

In 1977, Klein et al. reported two patients with *S. bovis* endocarditis who also had carcinoma of the colon.² This prompted an investigation of the relationship between *S. bovis* and colonic cancer. They found an increased carriage rate for this particular organism in patients with colonic cancer. It is unclear at the present time why this relationship occurs but this observation has been confirmed by several other investigators.^{3,5} However, subsequent reviews have shown that this association is not confined solely to colonic cancer.^{6,7} In a larger series, benign colonic disease also was associated with *S. bovis* endocarditis.² The Mayo Clinic experience⁸ showed that in their 81 cases of infective endocarditis due to viridans streptococci, 22 percent were caused by *S. bovis*. Fourteen of 23 patients with *S. bovis* endocarditis were subsequently found to have colonic disease. Of these, 5 patients had inflammatory bowel disease, 3 patients had colonic polyps, 3 patients had bleeding diverticula, 2 patients had villous adenoma, and 1 patient had carcinoma of the colon. In a prospective study, Klein

et al. showed that *S. bovis* septicemia is not only associated with colonic disease but also with noncolonic gastrointestinal lesions.⁹ In their series of 29 patients, 2 patients had carcinoma of the esophagus, 1 patient had carcinoma of the stomach, and 1 patient had gastric lymphoma. Two patients had diverticular disease, 1 in the esophagus, and 1 in the duodenum.

CONCLUSION

In reviewing all these studies, it appears that *S. bovis* is not only associated with colonic cancer but also associated with benign colonic disease and lesions of the upper gastrointestinal tract. In view of these observations, it therefore is important to realize that when *Streptococcus bovis* is identified as the etiologic agent in bacteremia or infective endocarditis, a thorough search for colonic cancer and a complete evaluation of the gastrointestinal tract is necessary in order not to miss this important association.

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CASE REPORT: UNUSUAL PHARYNGEAL PERFORATION

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Accidents can occur during routine daily activities with potential serious morbidity. A mishap during tooth brushing, its health consequences, and management lessons are illustrated.

Forceful head and neck trauma in this age of automobiles and weaponry commonly are treated

by specialists with well-defined rules of management. Not often seen are penetrating pharyngeal injuries in adults. The potentially serious nature of this event may be minimized by both the patient and physician with a disastrous outcome. This following case report is presented to demonstrate a seemingly trivial injury, diagnostic modalities, treatment choices, anatomical factors, and potential complications.

CASE REPORT

After brushing her teeth one morning, a 40-year-old woman hurriedly leaned forward and accidentally drove the blunt end of the toothbrush into the back of her mouth while the brush was braced against the sink. There was severe pain without bleeding noted. She disregarded this and compulsively attended her aerobic exercise class for about an hour, after which she did not feel well and went to bed. Pain in the left lateral neck area made her seek medical attention.

At the Riverview Medical Center emergency room seven hours after the trauma, crepitation was felt in the neck and air was seen laterally and posteriorly to the esophagus (Figures 1 and 2). What was thought to be the entry point was seen as a sealed 1 cm red mark above the left tonsil. Chest pain and a pericardial friction rub were noted.

The patient was admitted on the surgical service and consultations were obtained with otolaryngology, pulmonary medicine, and infectious disease specialists. Intravenous penicillin, Cleocin™, and gentamycin were administered, but no oral feedings were permitted.

The initial white blood count (WBC) was 21,800. The EKG and esophogram were normal. The course was monitored by symptoms, physical examination, temperature, white blood counts, and soft tissue radiographs of the neck. The WBC fell to 16,000 and then to 12,600. X-rays of the neck showed that the air was gone after five days. She remained afebrile. The dysphagia, neck pain, and chest discomfort diminished over four to five days and was gone in one week. Minimal neck swelling over the area of the carotid pulse resolved and the mouth lesion faded. The gentamycin was discontinued and the patient was placed on oral penicillin and Cleocin™ which was continued after discharge for a total of three weeks. Colitic symptoms responded to a short course of Flagyl® (metronidazole). All neck and chest symptoms had subsided at a subsequent office followup. A sputum culture in the hospital grew parainfluenzae and *Klebsiella pneumoniae* organisms.

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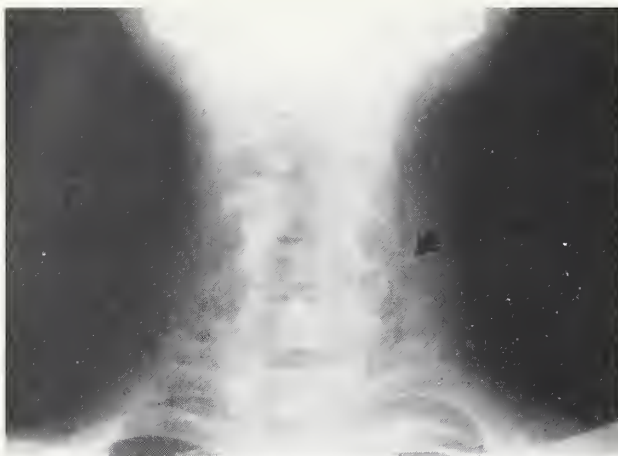


Figure 1—Arrow points to air in the lateral neck.



Figure 2—Arrows point to air behind the esophagus and anterior to the vertebral column.

DISCUSSION

An oblique penetrating wound above the palatine tonsil would enter the lateral pharyngeal space and communicate to the retropharyngeal space, also called the retrovisceral space (Figure 3).¹ In this patient, pain and swelling in the carotid area can be anticipated by the Valsalva maneuver during exercise, forcing air and saliva along the adventitia of this vessel. The retropharyngeal space connects to the mediastinum (Figure 4) and the chest pain and pericardial signs point to this.

The literature review was interesting in that it re-

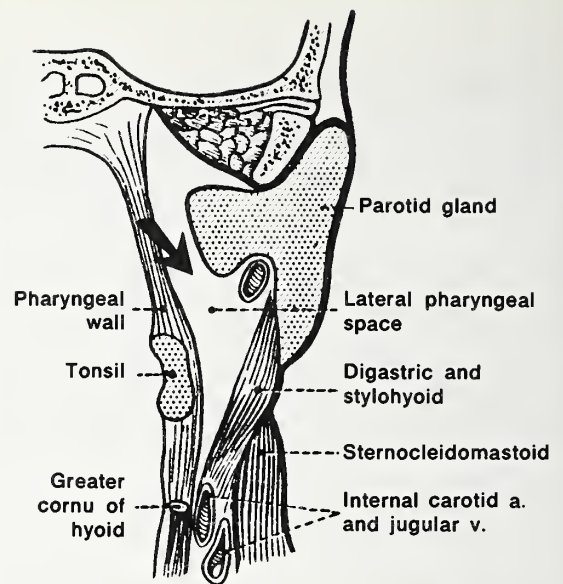


Figure 3—Arrow points to the lateral pharyngeal space with reference to the tonsil (©Lippincott/Harper & Row Publishers).

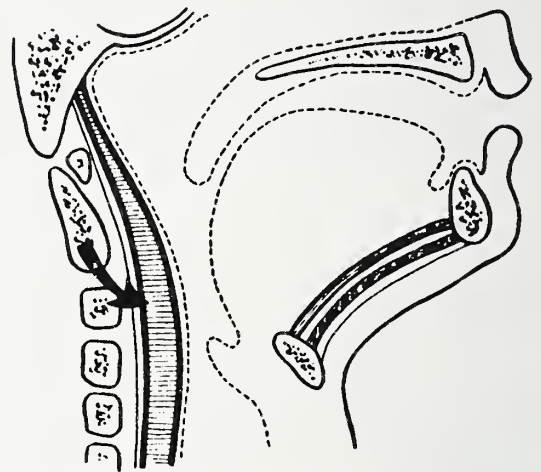


Figure 4—Arrow points to retropharyngeal (visceral) space (©Lippincott/Harper & Row Publishers).

vealed that most penetrating pharyngeal wounds are in young children falling on a sharp object held in the mouth.² Coincidentally, one such individual was an 18-year-old who slipped while brushing his teeth and contused his paratonsillar area.³ Newborn infants sustain penetrating wounds in this area during intubation and suctioning.⁴ Intraoral trauma in this zone may result in severe major neurological deficits due to thrombosis of the internal carotid artery.⁵ Infection of these spaces due to contamination must be treated; although gram-positive organisms are common, gram-negative bacteria also are found. Aerobic and anaerobic organisms are demonstrable.⁶

Injuries of this area can be treated medically, surgically, or a combination. In this case, careful clinical assessment permitted us to avoid surgical drainage. If signs of sepsis or deep space infection developed, an incision along the anterior sternocleidomastoid lateral to the thyroid and in the region of the carotid artery could be employed. Broad antibiotic coverage is needed because of varied flora. Long-

term followup is necessary to rule out delayed infection.

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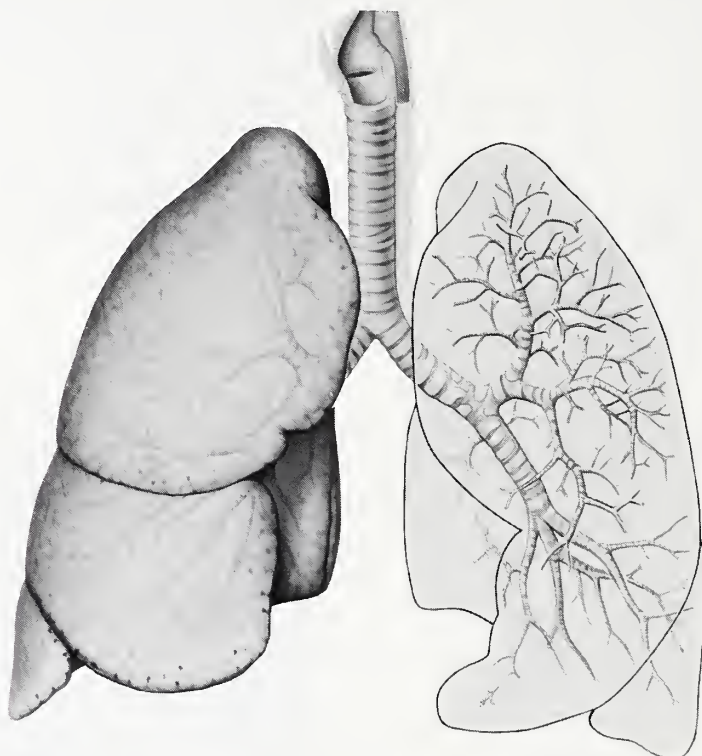
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Consider the causative organisms...



Cecilor[®] cefactor 250-mg Pulvules[®] t.i.d.

**offers effectiveness against
the major causes of bacterial bronchitis**
H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Cecilor[®] (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cecilor.

Contraindication: Cecilor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS ALLERGICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cecilor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, manage-

ment should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: **General Precautions**—If an allergic reaction to Cecilor[®] (cefactor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids. Prolonged use of Cecilor may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cecilor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended. As a result of administration of Cecilor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest[®] tablets but not with Tes-Tape[®] (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum

human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cecilor[®] (cefactor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Cecilor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Cecilor is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Safety and effectiveness of this product for use with Cecilor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cecilor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have

occurred in patients with a history of penicillin allergy. Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Cecilor[®] (cefactor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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OPINION: PREOPERATIVE MEDICAL CONSULTATION AND TREATMENT—AN ANESTHESIOLOGIST'S VIEW

MARK S. NEMIROFF, M.D., TRENTON*

An anesthesiologist discusses the importance of preoperative medical evaluation and preparation for the high-risk surgical patient. A team spirit between surgeon, anesthesiologist, and consultant benefits the patient and the professionals.

As the sciences of surgery and anesthesiology continue to develop, patients who once were thought to be at too high a risk, too ill, or too old to tolerate anesthesia and surgery now are being treated with ever-improving results and safety. In order to avoid or minimize perioperative medical complications, we ask medical and pediatric colleagues to participate actively in the management of high-risk patients. This participation frequently begins with a surgeon's request for medical consultation and treatment by the internist or pediatric consultant. The quality and usefulness of this consultation varies; occasionally, the consultant fails to provide the anesthesiologist and surgeon with all the useful information he possesses.

The anesthesiologist appreciates expert advice from his medical colleagues, for it is teamwork that will reduce operative morbidity and mortality in high-risk patients. A few case reports of typical high-risk surgical patients will demonstrate this teamwork and may suggest points that the medical consultant should omit or stress in his evaluation. Well meaning as the consultant may be, he may write notes on the chart that "order" the anesthesiologist to administer a drug or perform an anesthetic technique. This order may be against the anesthesiologist's better judgment and even may be dangerous to the patient. The wise physician does not follow poor advice from a well-meaning

medical colleague; conflicts between physicians that are recorded on the chart may result in legal problems at some later date should the patient or family become dissatisfied with the surgical outcome.

CASE REPORT 1

A 54-year-old male with coronary artery disease and hypertension was scheduled for a cholecystectomy with common bile duct exploration. He had a myocardial infarction two years ago and smokes a pack of cigarettes a day. His daily medications include Inderal®, Catapres®, and sublingual nitroglycerine.

Comment: With good perioperative management, there is every reason to expect this patient to do well, although he does present a number of obvious risk factors. The medical consultant should address the following issues in his preoperative consultation:

1. The patient's cardiac status since his infarction two years ago.
2. Perioperative management of the patient's coronary artery disease.
3. Management of medications for hypertension perioperatively. (He should recommend drugs for use in the event of a hypertensive crisis.)
4. Assessment of pulmonary function.

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The patient should be required to stop smoking well before surgery. If the medical consultant is a long-time physician of the patient, he would be the most likely physician to accomplish his goal.)

The anesthesiologist does not want to read on the medical consultant's note "avoid hypoxemia, avoid hypotension, give spinal anesthesia, and tell the anesthetist to check the electrocardiogram during surgery." Such advice is not only useless, it is insulting!

CASE REPORT 2

A 36-year-old markedly obese woman with diabetes mellitus and a history of pulmonary embolus six months ago, is scheduled for elective repair of an inguinal hernia. Her medications include insulin, Coumadin®, and Valium®. Preoperative arterial blood gas study on room air revealed elevated $p\text{CO}_2$.

Here is an opportunity for teamwork between the various consultants to reduce surgical and anesthetic risk. This case is not unusually complex or rare for most community hospitals. Important concerns include the following:

1. The dose, time, and route of insulin administration are important. What other organ systems are involved by the diabetes, e.g. renal disease? A preoperative regimen suited for the patient will include timing and type of intravenous solutions to maintain homeostasis during the perioperative fast. Blood glucose determinations before surgery, on arrival at the holding room, and during and/or after surgery also are needed.

2. Coagulation profile, elastic stockings, and a plan for the earliest possible ambulation to minimize the risk of pulmonary embolus should be considered.

3. Thorough assessment of pulmonary function is essential before surgery. It would be helpful psychologically to the patient and family to warn them of the possible need for postoperative ventilation assistance and monitoring in the intensive care unit.

Comment: Most pediatricians and internists have been exposed to anesthesiology for a few weeks during medical school or residency. Solutions to the many problems presented in case report 2 are more complex than those of case report 1. Furthermore, concepts that may have been valid when the medical consultant was exposed to anesthesiology are likely to be outdated. Improvements in monitoring, new anesthetic agents, and adjuvant drugs have changed the modern anesthetist's approach to these problems. It is inappropriate for the medical consultant to recommend a specific anesthetic, drug, or technique. It equally would be inappropriate for the anesthesiologist, who no longer is familiar with treating patients with antibiotics, to treat a patient for pneumonia. Each special-

ist should concentrate on what he knows best. The medical consultant should not insist on a particular anesthetic technique and the anesthesiologist should not insist on a particular form of medical management. In fact, the medical consultant who emphasizes a particular anesthetic in his preoperative note may be compromising his anesthesiologist colleague legally. Attention surely will be drawn to any conflict of opinion between consultants in the event of an adverse outcome, and may stimulate litigation.

CASE REPORT 3

A 40-year-old man with a long history of alcohol abuse, poor liver function, and ascites was hit on the head with a bottle in a fight. He gradually lost consciousness. He is being prepared for an emergency craniotomy for a suspected intracranial hemorrhage.

Comment: By this point, the reader can anticipate some of the things which the anesthesiologist would like to note in the preoperative medical consultation. In this critically ill patient, an astute medical evaluation becomes an invaluable aid to the anesthesiologist. Please do not write, "Avoid hepatotoxic drugs." The anesthesiologist mainly is concerned with preservation of the patient's neurologic function. The issue of toxicity of halogenated anesthetics to this day remains controversial and is not an important factor in this patient's management. This case raises many critical issues, but I will let the reader evaluate them and consider the respective roles of the consultant, the anesthesiologist, and the neurosurgeon.

CONCLUSION

I have avoided trying to review literature, and refer the interested to several books on the subject of preoperative management of acutely ill patients.

It would not be possible to discuss all the issues involved in the medical and anesthetic management of these patients, even if the entire issue of *The Journal* were devoted to the subject. I hope I have stimulated thought on a complex problem, and this will open lines of communication between medical specialists. Let us resolve to make the preoperative medical consultation an important factor in the reduction of surgical and anesthetic risks for the benefit of our patients.

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DOCTORS' NOTEBOOK

Trustees' Minutes; UMDNJ Notes; New Members; Physicians Seeking Location in New Jersey

Trustees' Minutes May 1, 1985

A regular meeting of the Board of Trustees was held on May 1, 1985, at the Americana Host Farm Resort, Lancaster, Pennsylvania. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Committee on Publication . . . Approved the following recommendation:

That the name of the journal of the Medical Society of New Jersey be changed to *New Jersey Medicine*, with the current title (*The Journal of the Medical Society of New Jersey*) as the subtitle.

Committee on Biomedical Ethics . . . Approved the following recommendation:

That Dr. Nevins be advised that the Committee on Biomedical Ethics has reviewed his correspondence, the Conroy decision, and other related developments and has revised the Supportive Care Plan Guidelines for Nursing Home Residents

accordingly, by deleting item 8, under Section B—How Decisions Should Be Made: 8, *Expedited review by the Supportive Care Plan Review Committee before implementation.* (Italics indicate deletion.)

Old Business . . .

(1) Right To Know Law . . . Received a communication from Dr. Altman, Assistant Commissioner, Division of Epidemiology and Disease Control, State Department of Health, indicating that the problem concerning the reporting of hazardous substances on the workplace survey has been corrected.

(2) Peer Review Organization of New Jersey, Inc., Liaison Committee . . . Noted that the question of MSNJ's representation at PRO Board meetings is being discussed by the PRO Board.

(3) Ad Hoc Committee on Health Care Reimbursement Policies . . . Approved the formation of this committee and noted its goals: 1) to identify, become familiar with, and monitor the principal forms of medical care delivery, and the various forms of reimbursement to physicians and hospitals for medical services provided in each form of medical care delivery; 2) to keep the Board up to date regarding the various forms of medical care delivery through periodic reports; and 3) to recommend to the Board policies for MSNJ regarding the various forms of medical care delivery.

New Business . . .

(1) Blue Shield Fee Reduction . . . Approved the following statement:

The Medical Society of New Jersey has received a request from the chairman of the Board of Blue Shield to urge Society members to reduce their fees to Blue Shield by 5 percent because of a large deficit in the Blue Shield Plan.

The Medical Society of New Jersey does not know the nature and extent of the Blue Shield deficit but is aware that the financial base of the Plan has been eroding in the last few years.

Members of the Society engaged in a voluntary fee freeze for this past year. Additionally, the federal government froze payments to physicians under Medicare from October 1, 1984, to September 30, 1985. During this same time period the costs of goods and services necessary to physicians in their practices have risen unchecked. Malpractice insurance alone rose by over 24 percent.

Physicians cannot be expected to bear the cost overruns of the government or private industry. Likewise, the Medical Society of New Jersey cannot at this time urge its members to reduce their fees to Blue Shield. That would give Blue Shield an unfair competitive advantage over other insurers and purchasers of care. It also should be noted that Blue Shield fees have been frozen for the past year.

The Blue Shield fee freeze coupled with the Medicare freeze has resulted in some physicians finding it difficult to continue treating Blue Shield and Medicare patients. A Blue Shield reduction can only exacerbate these problems since at present Blue Shield payments are based on 1982 charges.

The Society fully recognizes the importance of a sound Blue Shield Plan to the people of New Jersey and will do its best to resolve those issues it can. Until the details of the Blue Shield situation have been presented to the Society and analyzed, we cannot take action on the Blue Shield request.

Also, supported the ruling that it was inappropriate for MSNJ to act on the request made by Blue Shield that participating physicians reduce their fees by 5 percent because of the large Blue Shield Plan deficit.

(2) Request for Open Hearing on New Jersey Hospitals . . . Directed that a request for an open hearing concerning the deteriorating impact of the New Jersey Medicare waiver and certificate of need process on New Jersey hospitals be implemented.

(3) Committee on Medical Education Accreditation . . . Noted that the Committee on Medical Education has been evaluated by the Accreditation Council for Continuing Medical Education.

Retiring Members of the Board of Trustees . . . Extended sincere appreciation to Drs. Kovacs and Morrison for their years of service.

Chairman of the Board . . . Noted from Dr. Watson that with the completion of the first administrative year in which the duties of president and chairman of the Board were combined had gone well.

Trustees' Minutes May 5, 1985

A reorganization meeting of the Board of Trustees was held on May 5, 1985, at the Americana Host Farm Resort, Lancaster, Pennsylvania. De-

tailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Reorganization . . .

(1) Introduction of New Members . . . Officially welcomed Dr. Fred M. Palace and Dr. Joseph P. Zawadsky.

(2) Chairman of the Board of Trustees . . . Noted that Dr. Fioretti will serve in the dual role as President and Chairman of the Board.

(3) Commendation to Former Chairman . . . Gratefully acknowledged the outstanding contribution made by Dr. Frank Y. Watson.

(4) Meeting Schedule for 1985 to 1986 . . . Voted to continue meeting at 10:00 A.M., on the third Sunday of each month at MSNJ headquarters.

Standing Committee on Finance and Budget . . . Unanimously appointed Edward A. Schauer, M.D., to a three-year term on the Standing Committee on Finance and Budget.

New Jersey Hospital Association . . . Reappointed Frank Y. Watson, M.D., as MSNJ's liaison representative to the Board of Trustees of the New Jersey Hospital Association.

Old Business . . .

State Board of Medical Examiners' Proposed Business Practice Rule

. . . Approved, as amended, a position statement submitted by the Executive Committee; noted that Dr. Fioretti and Mr. Maressa will represent MSNJ at a public hearing on the subject.

New Business . . .

(1) 1985 House of Delegates . . . Approved the following recommendations made by the President:

(a) Resolution #2—Quality of Care . . . Approved referral of the following Resolution to the Executive Committee for development of a conflict of interest disclosure questionnaire:

Resolved, that MSNJ advise the membership that it is inappropriate to be in the employ of the PRO while active within MSNJ offices, councils, committees, and representative positions.

(b) Resolution #7—Decision for the Establishment of Facilities To Be the Prerogative of the Hospital Board of Trustees . . . Approved re-

ferral of the following Resolution to the Council on Legislation for implementation:

Resolved, that MSNJ adopt and promote the position that facilities in hospitals be determined by its Board of Trustees in concert with its medical staff via mutually approved projects, acting without interference from regulatory agencies on these determinations.

(c) Resolution #8—Quality of Medical Records . . . Approved referral of the following Resolution to the New Jersey Hospital Medical Staff Section for study and report.

Resolved, that MSNJ support the concept that only allied health personnel who have been successfully examined may be allowed to write notes on patient charts; and be it further

Resolved, that MSNJ develop the criteria and standards which comprise the examination to be taken by allied health personnel who would be authorized to write notes on patient charts.

(d) Resolution #9—Inappropriateness of DRG Remuneration . . . Approved referral of the following Resolution to the Ad Hoc Committee on Health Care Reimbursement Policies for study and report:

Resolved, that MSNJ study the entire reimbursement schedule of the DRG concept so that corrections can be requested when appropriate.

(e) Resolution #14—Preadmission Review/Certification . . . Approved referral of the following Resolution to the Council on Legislation, Council on Public Relations, AMA Delegation, Editor of *The Journal*, and Legal Counsel for implementation:

Resolved, that MSNJ institute an extensive public relations campaign to educate the public as to the dangers inherent in Preadmission Review/Certification; and be it further

Resolved, that MSNJ advise its members to voice opposition to Preadmission Review/Certification; and be it further

Resolved, that MSNJ investigate through its legal counsel, the advisability of a legal remedy to the oppressive regulations of Preadmission Review/Certification and institute such a course of action if found to be advisable by the Board of Trustees; and be it further

Resolved, that MSNJ shall notify all legislative representatives of the state of New Jersey, both on a state and national level, of the Society's strong opposition to Preadmission Review/Certification; and be it further

Resolved, that MSNJ shall present a

similar resolution to the American Medical Association House of Delegates.

(f) Resolution #26—New Jersey PRO Criteria . . . Approved referral of the following Resolution to the Executive Committee for a joint meeting with the Executive Committee of the PRO:

Resolved, that representatives of MSNJ have input into the New Jersey PRO criteria before they are released; and be it further

Resolved, that criteria promulgated by the New Jersey PRO be correctly labeled as a protocol to be used by nurse reviewers for establishing financial responsibility, and not intended as standards of medical practice to be met by physicians.

(g) Resolution #29—Scheduling of PRO Appeals . . . Approved referral of the following Resolution to the Executive Committee for a joint meeting with the Executive Committee of the New Jersey Hospital Association:

Resolved, that MSNJ prevail upon the PRO to schedule appeal hearings with the convenience of the appealing physician in mind, and that the date, time, and place for such hearing be discussed with the appealing physician in the first week of the 30-day appeal period rather than the last week; and be it further

Resolved, that the New Jersey Hospital Association urge its members to forward copies of hospital records to PRO at the time the appeal is requested.

Resolution #30—Prior Approval for Admission and/or Procedures for Patients . . . Approved referral of the following Resolution to the Executive Committee for a joint meeting with the Executive Committee of the New Jersey Hospital Association:

Resolved, that MSNJ formulate a document for patients to sign indicating that if permission in a "prior approval plan" is denied for procedures and/or admissions, the physician is not responsible for any untoward results; and be it further

Resolved, that MSNJ members be urged to make a note in their office records that they are not in agreement with the position of the carrier regarding the care of a patient; and be it further

Resolved, that MSNJ seek to have legislation enacted to hold the attending physician blameless for any harm to a patient occurring as a consequence of the PRO's refusal to authorize hospitalization.

(i) Resolution #24—Publicizing Costs of Nonpatient Health Care

... Approved referral of the following Resolution to the AMA Delegation:

Resolved, that MSNJ petition the AMA to search out an organization or agency to undertake a study of the costs of medical care and health care that relate to government mandates as opposed to actual patient care; and be it further **Resolved**, that the result of such studies be publicized widely to physicians, the media, and the appropriate politicians.

(j) Council on Public Relations . . .

Approved referral to the Committee on Finance and Budget and the Council on Public Relations of the request to provide sufficient funds to institute appropriate educational programs to support the physician-patient relationship.

(2) 1986 Annual Meeting . . .

Voted to schedule the next Annual Meeting at the Westin Bellevue Stratford in Philadelphia, on May 14 through May 18, 1986.

(3) Task Force on Senior Citizens

... Noted that A. Ralph Kristeller, M.D., has been appointed chairman of this new committee which is to meet on June 5, 1985.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

On June 13, UMDNJ dedicated the New Jersey Cancer Center at University Hospital. Four days later, UMDNJ welcomed entertainer Sammy Davis Jr. at a press conference to announce plans for developing the Sammy Davis Jr. National Liver Institute. The events, however, were more than mere formalities and their significance transcend Newark. They exemplify the important steps UMDNJ and the state of New Jersey are taking to combat two of the world's most dreaded diseases.

The opening of the Cancer Center means that New Jersey cancer patients will receive the most advanced treatment available in the country. No longer do New Jerseyans have to venture beyond the state's borders in order to receive state-of-the-art care.

Using intraoperative therapy—the revolutionary combination of surgery and radiation—tumors are surgically exposed and irradiated

with a linear accelerator, the most powerful radiation machine available. What is particularly exciting about this procedure is that it is available only at a few hospitals around the country. It also enables us to radiate only the cancerous site—not healthy skin, muscle, or organs—with an extremely concentrated dose of radiation. In addition, the accelerator has been strategically located adjacent to the operating room, allowing the patient to be transported from one room to the other with little risk of infection.

Sammy Davis Jr., the world-renowned entertainer, has vowed to invest "whatever is necessary" in order to make the liver institute bearing his name a success. A victim of liver disease himself, Mr. Davis will sit on an eight-member Executive Committee that also will include Dr. Carroll M. Leevy, scientific director and acting board chairman of the Institute; former Governor Brendan T. Byrne (who also attended the ceremonies); myself; Herbert Roemmele, chairman of UMDNJ's Board of Trustees; Dr. Vincent Lanzoni, dean, UMDNJ-New Jersey Medical School; Leonard Lopez, executive director of UMDNJ-University Hospital; and John Climaco, a Cleveland attorney associated with Mr. Davis. Lawrence A. Feldman, Ph.D., a faculty member of UMDNJ's Newark-based medical school, has been appointed chief administrative officer of the Institute.

Liver disease is the fourth leading cause of death in the United States among men aged 40 to 59, and is the number one cause in many third-world countries.

Until a separate facility can be constructed, the Institute will operate out of the medical school and University Hospital, where initial plans are underway to expand patient care and research programs. A proposed liver transplant unit and development of advanced diagnostic techniques—for early detection and treatment of liver cancer—are among future plans.

The Institute's kickoff fundraising event, a formal dinner-dance, is set for Monday, October 28, 1985, at the Loews Glenpointe Hotel in Teaneck. Another event is being planned for the west coast in the spring. We are very grateful to Mr. Davis for his time, interest, and dedication.

As you know, the health care field is changing rapidly. Our ability to diagnose and treat serious illness is improving almost daily, thanks to high technology. However, with this era of remarkable machinery and techniques come rising costs and dwindling funds: two factors that threaten not only the effectiveness of health care, but the well-being of thousands—perhaps millions—of patients as well.

Therefore, this terrible dichotomy mandates action, lest health care become a commodity only for the wealthy. Academic-industrial cooperation is one solution.

With this in mind, UMDNJ sponsored "Corporation Day" on June 5. Under the direction of Saul Schepartz, Ph.D., the university's associate vice-president for academic-industrial relations, more than 50 scientists and research directors from pharmaceutical companies in four states learned of innovative de-

300 YEARS OF MEDICINE IN NEW JERSEY

Copies of this special issue, published in September 1984, still are available. Highlighting the history of medicine, this issue illuminates the beginnings of our health care system and the growth of medical care in the Garden State. Send \$5.00 to the Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.

velopments in research and care from 36 faculty members representing UMDNJ's three medical schools and its dental school.

The day-long conference—held in seven simultaneous sessions, divided according to specialties and interests—included presentations on artificial skin, unique orthopedic biomaterials, new pharmacological aspects of treating Parkinson's disease, and new developments in pain control, to name but a few.

There is much interest in the public and private sectors for increased cooperation, and UMDNJ has been encouraging faculty to bring any possibly patentable work to the attention of the university administration so that licenses can be sought.

Moreover, as Dr. Schepartz has noted, both the University and pharmaceutical companies may be in need of laboratory and research facilities that can be met through mutual accommodation. There also may be other common interests and needs. And when one considers that New Jersey has the highest concentration of pharmaceutical companies in the nation, the possibilities of partnerships with industry become even more exciting.

New Members

We would like to welcome the following new members to the Medical Society of New Jersey.

Atlantic County

Eddie A. Flori, M.D., Linwood
Ronald A. Loewe, M.D., Pomona

Bergen County

Kathleen M. Cerkvenik, M.D., Wyckoff
James R. Clifford, M.D., Ramsey
Franco Diaz, M.D., Hackensack
Beverly A. Dunn, M.D., Mahwah
Amina Elkassir, M.D., Fort Lee
Alan Feldman, M.D., Midland Park
Zvi H. Fischer, M.D., Fair Lawn
Miriam Fishman, M.D., Englewood
Julie M. Fortunato, M.D., Westwood
Enrico Frigeri, M.D., Fort Lee
Rajinder P. Gandhi, M.D., Ridgewood
David J. Goldberg, M.D., Westwood
Abraham T. Haliczzer, M.D., Edgewater
Uzma Khalid, M.D., Hawthorne
Jeffrey P. Kozlowski, M.D., Midland Park
Young B. Lee, M.D., Englewood
Youngick Lee, M.D., Ridgewood
Helene B. Leonetti, M.D., Hackensack
Philip R. Lesorgen, M.D., Tenaflly
Donna E. Nickles, D.O., Hawthorne
Alexander M. Panossian, M.D., Park Ridge
Paul M. Parker, M.D., Old Tappan
Janet P. Parler, M.D., Englewood
Bernard Schuman, M.D., Paramus
Manuel A. Vega, M.D., Hackensack

Burlington County

Michael I. Zalkin, M.D., Willingboro

Camden County

Bruce A. Barron, M.D., Voorhees
Walter Poprycz, M.D., Camden
Karen M. Scardigli, D.O., Cherry Hill

Cumberland County

Owen J. Sheekey, M.D., Vineland

Essex County

Susan Bershad, M.D., Montclair
Jeffrey D. Blonstein, M.D., Maplewood
Arthur S. Butensky, M.D., West Orange
Kokila S. Chandarana, M.D., Edison
Maria S. Flores-Dieppa, M.D., Irvington
James K. Freyne, M.D., Newark
Michael S. Imbrogno, M.D., Maplewood
Albert A. Kowalski, M.D., Cedar Grove
John D. Napoli, M.D., Belleville
Charles F. Rilli, M.D., Belleville
Anthony G. Rossi, M.D., Cedar Grove
Michael M. Rothkopf, M.D., Newark
Rebecca L. Steckel, M.D., Montclair
Nicholas W. Tangreti, M.D., West Orange

Gloucester County

Craig H. Rosen, M.D., Woodbury

Hudson County

Mitchell J. Mutterperl, M.D., Bayonne

Mercer County

Jeffrey T. Apter, M.D., Princeton
Nancy L. Feldman, M.D., Trenton
Paul E. Goldberg, M.D., Lawrenceville
Richard L. Levine, M.D., Lawrenceville

Middlesex County

Richard C. Angrist, M.D., Somerset
Michael Fizicki, M.D., Parlin
Marsha M. Kallich, M.D., Highland Park
Youn Kang Oh, M.D., Edison
John L. Tamminen, M.D., Plainsboro
William R. Wasserstrom, M.D., East Brunswick

Morris County

Corrado J. Altomare, M.D., East Hanover
John P. Feltz, M.D., Florham Park
Helen L. Miller, M.D., Kinnelon
Arturo D. Monta, M.D., Wharton
Farhad Rafizadeh, M.D., Morristown
Carmen M. Renna, M.D., Morristown
Richard F. Taylor, M.D., Dover

Ocean County

Morrow C. Corvasce, M.D., Point Pleasant

Passaic County

Lawrence Kraut, M.D., Clifton
Stephen I. LaPoff, M.D., Clifton
Adam Lesiczka, M.D., Wallington
Peter Markalous, M.D., Northvale
Kenneth J. Paonessa, M.D., Elmwood Park
Joseph A. Pena, M.D., Wayne
Gary Ronay, M.D., Clifton
Govindasamy Sankaranarayanan, M.D., Clifton
Simon B. Santos, M.D., Passaic

Somerset County

Alissa B. Fox, M.D., Somerville
Michael A. Fragoso, M.D., Bridgewater
Elizabeth M. Gregory, M.D., Somerville

Union County

James Z. Cinberg, M.D., Elizabeth
Aristides B. Codoyannis, M.D., Newark
David M. Corwin, M.D., Elizabeth
Antonio R. Diaz, Jr., M.D., East Cranford
Francis J. Foca, M.D., Summit

Robert I. Greenblatt, M.D., Elizabeth
Robert C. Lauer, M.D., Plainfield
Paul K. Lerer, M.D., Riverdale, NY
Bruce D. Oran, D.O., Summit
Steven I. Wolinsky, M.D., Westfield

Warren County

Patrick G. Convery, M.D., Budd Lake

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Howard Yap Ang, M.D., 2957 Decatur Ave., Apt. C-43, Bronx, NY 10458. Far Eastern University (Manila) 1976. Board eligible. Solo, partnership, group. Available.

Vasant Chheda, M.D., 950 49th St., Apt. 8K, Brooklyn, NY 11219. G.S. Medical College (India) 1978. Fee-for-service, solo, group, partnership. Available.

John James, M.D., 950 49th St., Apt. 8K, Brooklyn, NY 11219. G.S. Medical College 1978. Solo, partnership, fee-for-service, group. Available.

CARDIOLOGY—Bruce Klein, M.D., 438A Willow Turn, Mt. Laurel, NJ 08054. SUNY-Downstate 1977. Also, pediatrics. Board certified (PD). Group, HMO, hospital. Available.

DERMATOLOGY—Rami Ephraim Geffner, M.D., 1139 N. Church St., Apt. A-3, Greensboro, NC 27401. UMDNJ 1979. Group, solo, partnership. Available.

FAMILY MEDICINE—Mark T. Bright, M.D., 1718 Afton Ave., Charleston, SC 29407. Georgetown 1978. Board certified. Group or partnership. Available September 1985.

Steven Luke, M.D., 3246 Abell Ave., Baltimore, MD 21218. SUNY 1982. Board eligible. Group or HMO. Available.

Daniel Nuchovich, M.D., 1006 Bay Drive, #702, Miami Beach, FL 33141. University of Uruguay 1980. Health center, hospital, underserved area. Available.

INTERNAL MEDICINE—Diane Bruzzi, M.D., 638 Colonial Arms Rd., Union, NJ 07083. St. George University (West Indies) 1982. Board eligible. Group, partnership, clinic, nursing home. Available.

Harold B. Ehrlich, M.D., 41 Elmwood Ave., Union, NJ 07083. St. George University (West Indies) 1982. Board eligible. Group, partnership, clinic, nursing home. Available.

Leonid Goldin, M.D., 1802 Ocean Pkwy., Apt. D2, Brooklyn, NY 11223. Kursk (USSR) 1968. Group, hospital, nursing home, institution. Available.

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, The Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the UMDNJ. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

CARDIOLOGY

October

- 10 Controversies in Cardiology**
7:30 A.M.-1 P.M.—Newark Beth Israel Medical Center (AMNJ)

MEDICINE

September

- 12 Smoking: Its Effects on Smokers and Nonsmokers**
7:45-9:15 P.M.—Memorial Hospital of Burlington County, Mount Holly (Burlington County Medical Society and AMNJ)
- 18 Hepatitis B Virus Infection: Implications for the Health Care Professional**

1-2 P.M.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

- 18 Dermatological Conferences**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, New Brunswick (UMDNJ and AMNJ)
- 19- Advances in Pain Management**
- 20** 8 A.M.-5 P.M.—Resorts International, Atlantic City (UMDNJ-New Jersey Medical School and AMNJ)
- 26 Conversational Genes and Designer Genes**
11 A.M.-12 noon—St. Joseph's Hospital, Paterson (St. Joseph's Hospital and Medical Center and AMNJ)

October

- 2 Metabisulfite Sensitivity**
8-9 P.M.—The Manor, West Orange (NJ Allergy Society and AMNJ)
- 3 Conversational Genes and Designer Genes**
- 10** 11 A.M.-12 noon—St. Joseph's Hospital, Paterson (St. Joseph's Hospital and Medical Center and AMNJ)
- 31** 9 A.M.-12 noon—St. Joseph's Hospital, Paterson (St. Joseph's Hospital and Medical Center and AMNJ)
- 9 Structured Interventions with Alcoholics and Other Chemically Dependent Persons**
9 A.M.-4 P.M.—Medical Society of New Jersey, Lawrenceville (Impaired Physicians Program, MSNJ, and AMNJ)
- 16 Cell Surface Receptors: Structure and Function**
1:30-5:30 P.M.—Drew University, Madison (Drew University, CIBA-Geigy Pharmaceutical Division, and AMNJ)
- 16 Dermatological Conferences**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, New Brunswick (UMDNJ-Rutgers Medical School and AMNJ)
- 26 An Overview of Military Surgeons in the 20th Century and How They Functioned**
8:15 A.M.-1:15 P.M.—Fort Dix Base (AMNJ)

NEUROLOGY/PSYCHIATRY

September

- 5 Biological Markers in Psychiatry**
- 12 Allergies Update for the Physician**
- 19 Adolescent Sexuality**
12 noon-1 P.M.—Carrier Foundation, Belle Mead (Carrier Foundation)
- 10 What's New in the Management of**

Depression?

2:30-4 P.M.—Marlboro Psychiatric Hospital
(Roerig Pharmaceuticals/Marlboro Hospital and AMNJ)

- 17- Second Annual Psychiatric Nursing Symposium**
9 A.M.-5 P.M.—Hyatt-Regency Hotel, Princeton (Carrier Foundation and NAPPH)
- 27 Fifth Anniversary Dedication of the Mollie and Jerome Levine Neuroscience Research Laboratory**
9 A.M.-5 P.M.—Rutgers Medical School, Piscataway (UMDNJ)

October

- 3 Diabetes Type 1—Pathogenesis, Diagnosis, Management**
- 10 Angina and Myocardial Infarction**
- 17 Legal Problems of Adoption and Child Custody**
- 31 Sleep Medications, Mood, and Depression**
12 noon-1 P.M.—Carrier Foundation, Belle Mead (Carrier Foundation)
- 23 XXV Annual Fall Symposium: Suicide**
9 A.M.-5 P.M.—Carrier Foundation, Belle Mead (Carrier Foundation)
- 24 Closed Head Injury**
8 A.M.-4 P.M.—Medical Education Bldg., Rutgers Medical School, Piscataway (UMDNJ)

SURGERY

September

- 10 Expanding Arthroscopic Procedures**
8-10 P.M.—Englewood Club, 115 Palisade Ave., Englewood (Englewood Surgical Society and AMNJ)

October

- 17 Trauma-Surgical Grand Rounds**
5-6 P.M.—Shore Memorial Hospital, Somers Point (Shore Memorial Hospital and AMNJ)
- 22 NASA and Space Medicine**
8-10 P.M.—Englewood Club, 115 E. Palisades Ave., Englewood (Englewood Surgical Society and AMNJ)

MISCELLANEOUS

October

- 23 The Press of Medicine: Trials, Tribulations, and Transplants**
7:45-9 P.M.—Englewood Hospital (Englewood Hospital and AMNJ)

8TH ANNUAL CURRENT CONCERNS IN ADOLESCENT MEDICINE

"A Practitioner's Guide To Teenage Health Care"

October 3 & 4, 1985 The Warwick Hotel, New York, NY

Sponsored by: Division of Adolescent Medicine, Dept. of Pediatrics, Schneider Children's Hospital, Long Island Jewish Medical Center, New Hyde Park, NY. Topics Include: Physicians Approach to Enhancing the Developmental Task of Adolescence; The Epidemic of Chlamydia in Teenagers; Management of Asthma in Adolescents; New Treatment Modalities for Acne; The Hypertensive Adolescent; Compliance Issues; Suicide and more. Credits: 13 Category 1 from the ACCME and AMA. Information: Ann J. Boehme, Associate Director for Continuing Education, Long Island Jewish Medical Center, New Hyde Park, NY 11042, (718) 470-8650.

LETTERS TO THE EDITOR

Child Abuse; Viral Diagnostic Lab

Child Abuse

May 20, 1985

Dear Doctor Krosnick:

The greater proportion of cases of child abuse never get reported to the state social agencies.

I am speaking of the widespread, religiously based medical neglect of children. This is done by direct physical abuse in the name of God, medical quackery, or avoidance of ordinary medical care that is life sav-

ing, based on the Bible—Jesus saves, heals, or cures.

During the past three-and-a-half years many children have died because of religious beliefs against medical care held by Christian Science, Faith Assembly, Faith Tabernacle, Faith Temple Doctoral Church of Christ in God, Church of the First Born, Christ Miracle Healing Center, Jehovah's Witnesses, and Christ Assembly.

(signed) Harold L. Scales, M.D.

REFERENCE

1. Children's Health Care Is a Legal Duty, Inc.: *World Medical News*, April 9, 1984, and January 23, 1984.

Viral Diagnostic Lab

May 17, 1985

Dear Doctor Krosnick:

With the generous assistance of the March of Dimes Birth Defects Foundation and UMDNJ, the Viral Diagnostic Laboratory was established in November 1983 and began operation in January 1984.

It was, and is, our conviction that the necessity for accurate and rapid viral diagnosis has become crucial for the practice of medicine in an optimal fashion. Reasons for this include selection of specific antiviral agents, specific diagnosis to avoid inappropriate treatment, specific diagnosis to aid in prognosis, the diagnosis of maternal viral infection to allow for preventive procedures such as cesarean sections in women with active herpes virus excretion,

the acquisition of epidemiologic knowledge, and the determination of the natural history and late sequelae of diseases. During the first year of operation of the laboratory, enterovirus, influenza virus, and parainfluenza virus isolation were not performed. Techniques for the isolation and identification of each of these have been added early in the second year of operation. A variety of

TABLE

Rutgers Medical School Viral Diagnostic Laboratory Specimens Submitted for Viral Identification, 1984

Total submitted	728
Total viruses identified	203
% positive for viral identification	28%
Herpes simplex viruses isolated	148
Cytomegalovirus isolated	36
Rotavirus identified	24
Herpes varicella zoster	11
Adenovirus	1

rapid identification techniques are used to allow for the fast identification of isolates. Approximately 50 percent of isolates are reported within 48 hours of acquisition and 95 percent within seven days. Specific quantitation of our first year's experience in viral isolation is summarized in the Table.

It is hoped that these efforts will allow the physicians of central New Jersey an opportunity to offer the most up-to-date medical care.

(signed) Lawrence D. Frenkel, M.D.

Director, Rutgers Medical School
Viral Diagnostic Laboratory

Annual Review of Neuroscience; Breast Imaging; Living with Diabetes; One-Day Plastic Surgery; Practical Surgical Pathology; Rapid Interpretation of Heart Sounds and Murmurs

Annual Review of Neuroscience, Volume 8

W. Maxwell Cowan (ed). Palo Alto, CA. Annual Reviews, Inc., 1985. Pp. 603. Illustrated. (\$27)

Practicing physicians acquire their knowledge of the basic sciences in premedical and medical school. Once that training is completed, we turn our attention almost exclusively to things of a clinical nature. Few of us attempt to keep up-to-date on new developments in the basic sciences such as biology, embryology, and physiology and, in truth, we forget much of what has been learned in these disciplines. Our neglect of basic sciences seems unavoidable in view of the complexity of these subjects and the rapid explosion of knowledge about them, plus our struggle to learn and to keep current in the clinical side of medicine. Most of us probably are unaware of the great strides that are being made each year at very basic levels.

In this *Annual Review*, the progress in 18 different areas of very basic neuroscience is considered by separate groups of authors. Topics such as the GABA-ergic system, monoclonal antibodies, neuropeptides, cell lineage in the developing

embryo, and phototransduction in vertebrate rods are considered in quite sophisticated fashion. These topics, however elegant, provide little clinically useful information for the practicing physician. As an aside, one paper on the development of songs in birds may be of interest to bird lovers. The considerations of "Brain Stem Control of Saccades" and "Development of Vision in Primates" probably come closest to the interest of physicians in the clinical neurosciences.

This text is a very scholarly and current presentation of the remarkable progress being made in certain areas of the basic neurosciences. However, it is heavy reading for clinicians and of little practical value in patient care. Nevertheless, anyone who reads through these works will be impressed with the progress made in these areas, whether they studied basic science 5 or 35 years ago.

Stanley C. Leonberg Jr., M.D.

Breast Imaging, Third Edition

Robert L. Egan, M.D. Baltimore, MD, University Park Press, 1984. Pp. 180. Illustrated. (\$35)

Robert Egan, M.D., is internationally recognized as an expert in mammography, and as one of the pioneers in the development of this modality. This book is expressly written for radiographic technologists and expands upon two previous editions by the same author.

The initial four chapters of this text deal with the relevant historical perspectives of mammography, breast self-examination, physical examination of the breast, and normal breast development and anatomy. These chapters are excellent, and are recommended for both physicians and technologists. The text is supplemented generously by black-and-white illustrations of high quality, which are helpfully captioned.

The last four chapters are of the same high quality, dealing with questions commonly asked by patients about breast examination and with recommended guidelines for mammography. The last chapter of the book presents a comprehensive review of the risk-versus-benefit

ratio of this potentially life-saving procedure.

There is a splendid chapter on mammographic interpretation which would serve as an excellent review for radiologists involved in the interpretation of mammograms. This portion of the text is supplemented with line drawings and excellent illustrative mammograms.

The overall excellent quality of the book is marred slightly by scattered errors in the editing of the text and captions. Furthermore, the author seems to give more emphasis than is warranted to mammography performed with "conventional" radiographic equipment and nonscreen film, given the acknowledged improvement in film quality and markedly diminished radiation doses from dedicated radiographic units, xeroradiography, and the use of low-dose screen/film combinations.

Except for these small blemishes, the book is useful, and should be recommended to any hospital or practice involved in the care of women with breast disease.

Dirck L. Brendlinger, M.D.
Edwin S. Wilson, M.D.

Living with Diabetes

Genell J. Subak-Sharpe. New York, NY, Doubleday & Company, Inc., 1985. Pp. 291. Illustrated. (\$16.95)

This book, intended for patients, describes the diabetic self-care program of the Rockefeller and Cornell University researchers, Drs. Charles Peterson and Lois Jovanovic—the latter a diabetic herself. The program is intended to train the patient to adapt treatment to his individual lifestyle rather than the lifestyle to his treatment.

The program emphasizes tight control so that the blood sugar always is between 50 to 150. This is accomplished by home-glucose monitoring, exercise, and a diet tailored to fit individual preferences and lifestyles, as well as matching insulin to the individual meal plan. The accent is for the patient to take charge of diabetes with a freer and more flexible life.

The diet is rather low in carbohydrate (40 percent) and surprisingly high in fat (40 percent). The physicians consider the distribution of carbohydrate the most

important influence of the diet on the height of the blood sugar. Therefore, they match food and insulin by counting grams of carbohydrate rather than using exchange diets. Insulin is given before breakfast (NPH and Regular), Regular before supper, and NPH at bedtime. The patient further is instructed to adjust the dose or give a supplementary dose for changing circumstances during the day. The entire effort is to keep the blood sugar within the stated range at all times no matter what the circumstances. There is an excellent discussion of the use of the insulin pump.

This is not a book for self-treatment of diabetes; its use should be restricted to supplementing careful instruction and supervision by medical personnel familiar with this program.

Samuel E. Einhorn, M.D.

One-Day Plastic Surgery—A Consumer's Guide to Savings and Safety

Richard B. Bloomenstein, M.D., and Anne L. Finger. Great Neck, NY, Todd & Honeywell, Inc., 1984.

Dr. Bloomenstein and Ms. Finger have written a consumer guide regarding one-day plastic surgery. They have done this well and, in fact, go beyond the discussion of one-day surgery per se. Dr. Bloomenstein describes the operation under discussion quite well at several locations, and also provides his own pre-and postoperative instructions. Each chapter ends with a question-and-answer format providing further information.

It is interesting to note that the authors keep facelift patients overnight, thus it is not a one-day surgical procedure. Dr. Bloomenstein unequivocally recommends the male facelift to be done in a hospital setting.

The text is fairly complete and discusses all aspects of cosmetic procedures. The last chapter deals with how to choose a surgeon and how to decide whether to have the desired surgery done in an office setting or in a hospital.

The book is written in an informative way, and I am sorry to see that the illustrations are on the poor side

and quite limited.

Robby Meijer, M.D.

Practical Surgical Pathology

Zeynel A. Karcioğlu, M.D., and Ayten Someren, M.D., (eds). New York, NY, Macmillan Publishing Co., 1985. Pp. 1,235. Illustrated. (\$150)

Practical Surgical Pathology is a large and heavy book, so to use it comfortably one would need a table-top lectern, such as I use for my *Webster's Unabridged Dictionary*. It weighs slightly over ten pounds.

Including the two editors, there are 27 authors from many famous surgical pathology departments from both the United States and Canada. The text begins with an excellent foreword by Professor R.E.B. Hudson from Sussex, England. This is followed by a short preface in which the editors state the focus of the work is on surgical pathology with exclusion of most "medical" diseases, thus allowing more comprehensive coverage of surgical diseases.

There is an opening unnumbered section entitled, "Techniques in Surgical Pathology"; this is in seven pages with paragraphs on light microscopy, histochemistry, immunohistochemistry, electron microscopy, cytology, and flow cytometry. Then there are 26 chapters each concerning an organ, e.g. pancreas or an area, mediastinum. It appears the coverage of the body is complete. The final chapter, number 26, is entitled "Cytology in Surgical Pathology," and this includes seven pages on fine-needle aspiration biopsy. The index is complete and the references at the end of each chapter are current. Each chapter begins with a two-page discussion of the normal structure of the organ in that chapter. There are more than 2,200 illustrations, mostly black and white, and excellent photomicrographs. This book is printed on firm glossy paper and is well bound.

This is an excellent book. I believe this text should be on hand in every surgical pathology laboratory.

There is only question one might ask, "Is the price of \$150 worth it?" To put things in perspective, I took my wife to dinner and a play in New York City and with parking included

the evening came to well over \$100. So my answer to my question is a strong "yes." The book is far too detailed for medical students but it should be available to residents learning surgical pathology.

Hugh F. Luddecke, M.D.

Rapid Interpretation of Heart Sounds and Murmurs, 2nd Edition

Emanuel Stein and Abner J. Delman. Philadelphia, PA, Lea and Febiger, 1985. (\$18.50)

In the second edition of this tape and programmed text, heart sounds and murmurs are presented in a very basic manner geared to the needs of the beginning auscultator. The basic format has not changed from the first edition, but, in addition to the simulated heart sounds and murmurs which tend to be too harsh and exaggerated, there are some good quality recordings from actual patients.

The first side of the tape again is devoted to the four basic heart sounds, clicks, and opening snaps. The overly simplistic explanation of the underlying physiology (the first heart sound is relegated to A-V valvular closure alone) as well as the lack of reference to the effect of respiration on right and left-sided events are noted.

The second side of the tape again is devoted to murmurs. Included are various simulated and patient examples of systolic, diastolic, and continuous murmurs. All of the common valvular lesions as well as common congenital lesions are covered.

The tape generally is good but, even with a few patient examples, it suffers from the "tin-can" quality of the first recording. The differential diagnosis of most of the abnormal heart sounds and murmurs has been extended and now is much more complete. The "unknowns" again are presented and help reinforce the basic sounds and murmurs. The example of aortic regurgitation still is too harsh, loud, and difficult to time.

Despite its deficiencies this tape is well-designed for the beginning auscultator and covers the most important features of basic auscultation in a concise manner.

Daniel Lavery, M.D.

***Drs. Goodkin; Hauck;
Horan; King; Koven;
Lefkovics; McKeever; Patti;
Roberts; Stybel; Whitkin***

Dr. Edward Goodkin

An obstetrician and gynecologist in Union, Edward Goodkin, M.D., died on May 4, 1985, at his home after a long illness. Dr. Goodkin was only 55 years of age at the time of his death. A native of Paterson, he had received his medical degree from the Faculty of Medicine of Leiden (The Netherlands) in 1957. Dr. Goodkin was a member of our Union County component, and of the American Medical Association. He was board certified in his specialty, and a Fellow of the American College of Obstetricians and Gynecologists. Dr. Goodkin was affiliated with University Hospital, Newark, had been chairman of the obstetrics/gynecology department at Elizabeth General Hospital, and staff physician at St. Elizabeth Hospital, Elizabeth. He was assistant professor of clinical obstetrics and gynecology at UMDNJ-New Jersey Medical School. Very community-minded, Dr. Goodkin had served as mayor of Union, was Union County's Republican committeeman, had been involved with the Boys and Girls Club of Union and the March of Dimes, and was a former president of the Child Birth Education Association of New Jersey.

Dr. William H. Hauck

At the remarkable age of 94, William Henry Hauck, M.D., a family practitioner in Irvington for over 50 years, died on December 27, 1984. A native of Philadelphia, Dr. Hauck earned his medical degree at Jefferson Medical College in that same city, and was graduated in 1917. He was a member of our Essex County component, and of the American Medical Association. Dr. Hauck had been affiliated with Presbyterian Hospital, Newark, and Irvington General Hospital. The Medical Society of New Jersey conferred its Golden Merit Award on Dr. Hauck in 1967, honoring his 50 years in medicine.

Dr. Austin J. Horan

An ophthalmologist from Burlington County, Austin Joseph Horan, M.D., died on May 9, 1985, at the age of 70. Born in Pennsylvania, Dr. Horan received his medical degree from Jefferson Medical College, Philadelphia, in 1942. He established his practice in Mount Holly, later switching to Moorestown. At one time, he had been affiliated with Cooper Hospital, Camden, and more recently, with Burlington County Memorial Hospital, Mount Holly. Dr. Horan was a member of the American Medical Association.

Dr. Jack A.C. King

Just prior to his 65th birthday, Jack Austin Clinton King, M.D., died on April 26, 1985. A native of Metuchen, Dr. King was graduated in 1945 from Jefferson Medical College, Philadelphia. He established his practice in internal medicine in his native city and had affiliations with Perth Amboy General Hospital, and with the John F. Kennedy Medical Center, Edison. During World War II, Dr. King served in the medical department of the United States Army from 1946 to 1948. He had been a member of our Middlesex County component and of the American Medical Association.

Dr. Bernard J. Koven

The former chief of oncology at Hackensack Medical Center and Holy Name Hospital, Teaneck, Bernard J. Koven, M.D., died on May 2, 1985, at the untimely age of 58.

A native of New York City, Dr. Koven received his medical degree from Syracuse University Medical School in 1953. He was a Fellow of the American College of Physicians, and was board certified in medical oncology. Dr. Koven's list of hospital affiliations was impressive: it included, in addition to the two previously mentioned, Englewood Hospital; University Hospital, Newark; Jersey City Medical Center; St. Mary's Hospital, Passaic; Valley Hospital, Ridgewood; the Veterans Administration Medical Center, East Orange; Pascack Valley Hospital, Westwood; and Memorial Sloan-Kettering Hospital, New York City. He had received numerous awards from the American Cancer Society, and in 1979, he was named "Physician of the Year" by the society's New Jersey division. He had been a member of the Medical Society's Committee on Cancer Control for ten years and had been chairman of the Bergen County Medical Society's Cancer Committee.

Dr. Sidney Lefkovics

Sidney Charles Lefkovics, M.D., an obstetrician and gynecologist in Irvington for over 40 years, died at his home on May 4, 1985. Born in New York City in 1911, Dr. Lefkovics received his medical degree from Dalhousie University Faculty of Medicine, Halifax, Nova Scotia, in 1937. He was a member of our Essex County component, a Fellow of the International College of Surgeons, and a Fellow of the American College of Obstetricians and Gynecologists. Dr. Lefkovics had been affiliated with Saint Michael's Medical Center, Newark, and had a long affiliation with Saint Barnabas Medical Center, Livingston, where he had been chief of the ob/gyn section, and president of their board of trustees.

Dr. William J. McKeever

On April 22, 1985, at the age of 75, William Joseph McKeever, M.D., died at Wellington Hall Nursing Home, Hackensack. Born in Jersey City, Dr. McKeever received his medical degree from Long Island College of Medicine, Brooklyn, in 1939. Prior to his retirement in 1978, he practiced ophthalmology in his native city. He was a member of our Monmouth County component, and of the

American Medical Association. Dr. McKeever was a Fellow of the American and International Colleges of Surgeons. He had been affiliated with St. Francis Community Health Center, Fairmount and Greenville Hospitals, all in Jersey City.

Dr. Frank A. Patti

A retired general practitioner in Leonia, Frank Alfonso Patti, M.D., died on May 7, 1985, at the age of 78. Born in Bayonne, Dr. Patti received his medical degree from Long Island College of Medicine in 1931. He was a member of our Bergen County component, and of the American Medical Association. Dr. Patti was affiliated with Englewood Hospital and Holy Name Hospital, Teaneck. In 1981, the Medical Society of New Jersey conferred on Dr. Patti its Golden Merit Award honoring his 50 years in the medical profession.

Dr. Charles R. Roberts

A Teaneck psychiatrist, Charles Robert Roberts, M.D., died May 5, 1985, at the age of 73. A native of

New York City, Dr. Roberts earned his medical degree at the Royal College of Physicians and Surgeons, Edinburgh, Scotland, and was graduated in 1940. He had been a member of our Bergen County component, and was a Fellow of the American Academy of Child Psychiatry, of the American Psychiatric Association, and of the American Orthopsychiatric Association. Dr. Roberts was formerly medical director of the Child Guidance Center of the Oranges, Maplewood, and Millburn, and had been psychiatric consultant for social agencies in Essex County.

Dr. Joseph Stybel

An anesthesiologist from Plainfield, Joseph Stybel, M.D., died at Muhlenberg Hospital, Plainfield, on May 1, 1985, at the age of 78. Born in Brooklyn, New York, Dr. Stybel earned his medical degree at Loyola University, Chicago, and was graduated in 1932. He was a retired member of our Union County component, and of the American Medical Association. Dr. Stybel was affiliated with Muhlenberg Hospital, having

served as chief of their anesthesiology department. In 1982, the Medical Society of New Jersey conferred on Dr. Stybel its Golden Merit Award, to honor his 50 years as a physician.

Dr. Albert I. Whitken

On May 7, 1985, Albert Irving Whitken, M.D., a retired general practitioner in Elizabeth, died in Elizabeth General Medical Center at the age of 75. A native of Elizabeth, Dr. Whitken received his medical degree from Jefferson Medical College, Philadelphia, in 1934. He was a member of our Union County component, and of the American Medical Association. Dr. Whitken was affiliated with Elizabeth General Medical Center, and had served as chairman of the department of general practice. He was a Fellow of the American Academy of Family Practice. For many years, Dr. Whitken had served as physician to the Elizabeth board of education; he also had been president of Elizabeth General's clinical society. Dr. Whitken was a recipient of MSNJ's Golden Merit Award in 1984.

Style Sheet

The Journal is the official organ of the Medical Society of New Jersey. The goals of The Journal are educational and informational. All material published in The Journal is copyrighted by MSNJ.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the

source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—"®".

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

Physicians!

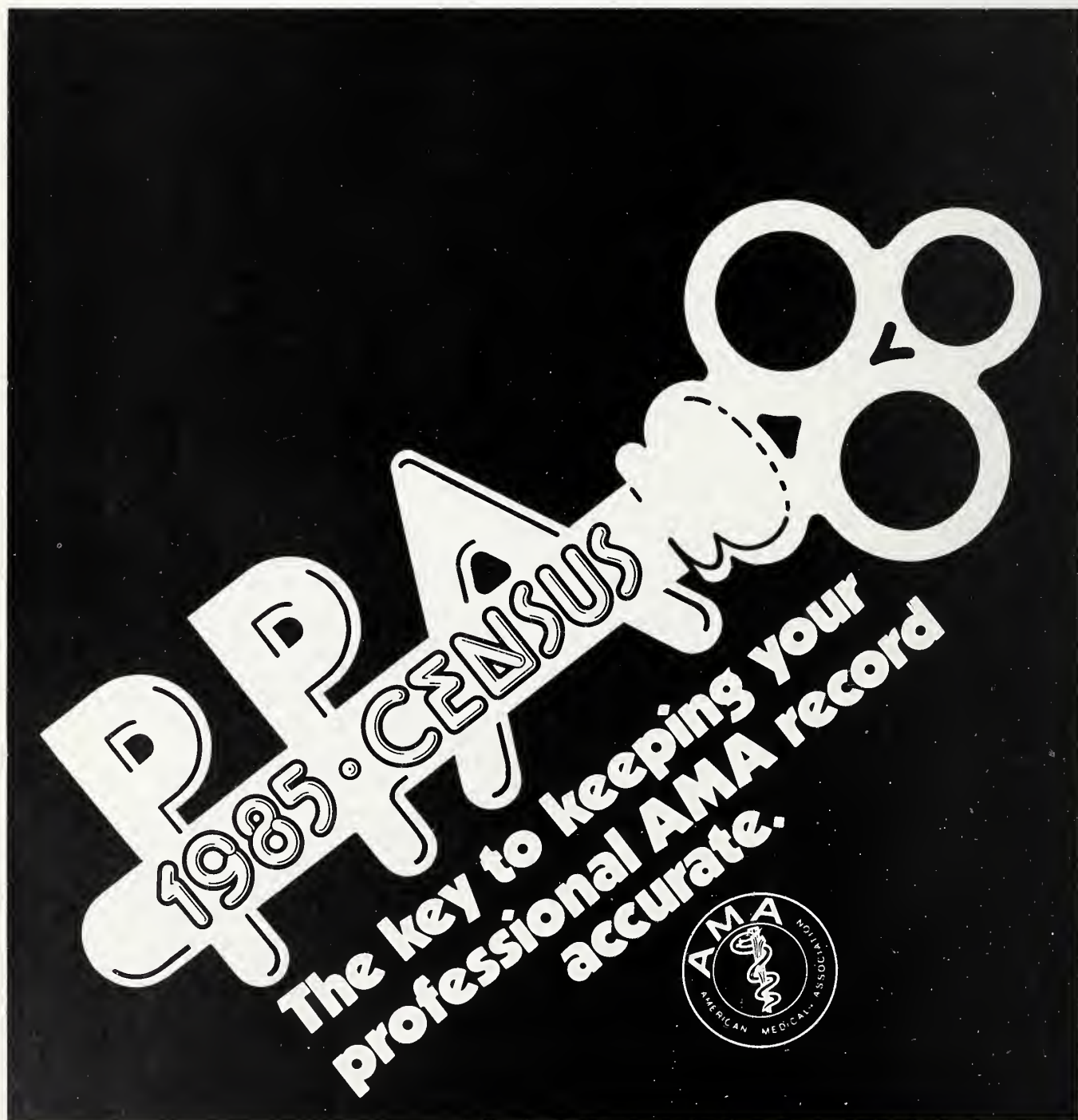
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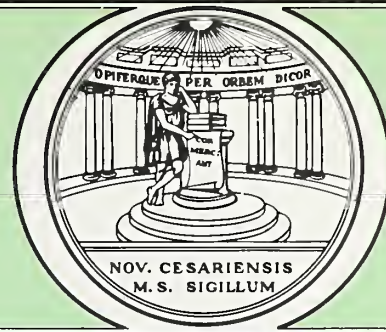
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MEMBERSHIP NEWSLETTER



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THE MEDICAL SOCIETY OF NEW JERSEY

VOLUME 26

GRADUATE MEDICAL EDUCATION FUNDING

The AMA testified concerning S-1158, a bill that would modify the existing Medicare direct medical education pass-through. The AMA opposed a one-year freeze on direct medical education costs unless it is part of an across-the-board freeze on all domestic and defense spending. The AMA stated that a cap on the number of residency years reimbursed by Medicare may have merit but should not be adopted without assurances that adequate funding will remain available for residencies with long-term training programs. The Association also supported eliminating Medicare reimbursement for the direct medical education costs of alien foreign medical graduates. The AMA recommended that some provision be made to allow an orderly transition for those hospitals that rely on alien FMGs to meet current patient care needs and that some consideration be given for such residents advanced in their training. (Testimony to the Health Subcommittee of the Senate Finance Committee, June 3, 1985.)

PROSPECTIVE RULE: HCPCS

The Division of Medical Assistance and Health Services intends to use the HCPCS Procedure Coding System beginning September 1, 1985. (HCPCS stands for the Health Care Financing Administration Common Procedure Coding System).

COLORECTAL CANCER

To increase awareness and thereby promote early detection, the American Cancer Society has mandated an aggressive and comprehensive three-year program called the Colorectal Health Check.

Colon cancer is the second leading visceral cancer in the United States, with an anticipated 138,000 new cases in 1985 (exceeded only by lung cancer with 144,000 new cases and compared to 119,000 new cases of breast cancer).

There has been considerable effort in investigating possible dietary and environmental causes or factors for this high prevalence; the precise cause of colorectal cancer remains unknown.

Therefore, while the American Cancer Society supports research into the causes and treatment of colorectal cancer, the main thrust of the Society's efforts has been toward early detection through education.

When the cancer is in its early stages, i.e. confined to the bowel wall, the cure rates should approach 75 to 80 percent. The problem has been the ability to detect these early lesions, which most often are asymptomatic. The clinical signs of blood in the stool, change in bowel pattern, abdominal cramps, and iron deficiency anemia too often reflect a later stage of disease.

The detection of asymptomatic cancer requires the appropriate use of a screening regimen. Appropriate screening implies two important points: a defined target population and an asymptomatic patient. Any patient with symptoms dictates the immediate need for thorough investigation. The recommendations for screening for colorectal cancer issued by the American Cancer Society are: 1) rectal examination yearly past the age of 40; 2) a stool blood test for occult blood done yearly after the age of 50; 3) proctosigmoidoscopy done for two consecutive years after the age of 50; if normal, then every 3 years.

We need to decrease the fears associated with this cancer. For example, we must show that only about 10 percent of patients will ever need a permanent colostomy, and that even life with a colostomy can be close to normal.

AMPAC CAMPAIGN MANAGER SCHOOL

An enthusiastic group of students graduated from the first AMPAC Campaign Manager School in July. Physicians, physicians' spouses, representatives of various state medical societies, and staff members from several congressional and senatorial campaigns spent long hours learning the state-of-the-art tech-

**ATTENDANCE AT BOARD OF TRUSTEES' MEETINGS: COUNTY SOCIETIES
JANUARY 1985-MAY 1985**

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May 1 Frank R. Romano, Sr., M.D., Past-President
May 5 Mrs. Ethel Stevens, Executive Director
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niques necessary to run, and run in, a modern-day political campaign. Fundraising, media, targeting, budgeting, and volunteer coordination were just a few of the campaign areas covered throughout the week. Participants also mapped out political strategy and developed campaign themes in an attempt to run a "winning" campaign for their respective group.

Mrs. Charles (Rina) Mintz of Millville represented New Jersey. The vital need for political participation among members of the medical community was stressed by Mrs. Mintz when she said, "If we, who understand what it means to be a part of medicine,

don't speak up and play a role in politics then I am afraid someone who doesn't understand physician issues will do it for us!"

For further information on participation in future Campaign Manager Schools, contact AMPAC at 1101 Vermont Avenue, N.W., Washington, D.C. 20005.

CANCELLATION OF MEDICARE PARTICIPATING PHYSICIAN AGREEMENT

Medicare participating physician agreements are automatically renewed on October 1, 1985, for the subsequent 12-month period. If you are participating

**ATTENDANCE AT BOARD OF TRUSTEES' MEETINGS: SPECIALTY SOCIETIES,
THE ACADEMY OF MEDICINE OF NEW JERSEY, AND AUXILIARY,
JANUARY 1985-MAY 1985**

New Jersey State Society of Anesthesiologists

January 20 Stanley Bresticker, M.D.
March 17 James R. Taylor, M.D., Vice-President

New Jersey Dermatological Society

January 20 Frederic Haberman, M.D., President

New Jersey Chapter, American College of Emergency Physicians

January 20 Rudolf E. Schwaeble, M.D.
February 17 Rudolf E. Schwaeble, M.D.
March 17 Rudolf E. Schwaeble, M.D.
April 14 Rudolf E. Schwaeble, M.D.

New Jersey Academy of Family Physicians

January 20 George L. Triebenbacher, M.D., President
February 17 George L. Triebenbacher, M.D., President
April 14 George L. Triebenbacher, M.D., President

Association For Hospital Medical Education of New Jersey

April 14 Arthur Gionti, M.D., President

New Jersey Society of Internal Medicine

February 17 Richard E. Dixon, M.D.
Huerta C. Neals, M.D., President-Elect
April 14 Frank J. Malta, M.D.
Huerta C. Neals, M.D., President-Elect
May 1 Frank J. Malta, M.D.

New Jersey Association of Medical Specialty Societies

January 20 Stanley Bresticker, M.D.
George L. Triebenbacher, M.D., President
February 17 George L. Triebenbacher, M.D., President
April 14 Frank J. Malta, M.D.
George L. Triebenbacher, M.D., President
May 1 Frank J. Malta, M.D.

New Jersey Obstetrical And Gynecological Society

January 20 John D. Franzoni, M.D.
April 14 John D. Franzoni, M.D.

Occupational Medical Association of New Jersey

March 17 Mary Ellen Cooney, M.D., Vice-President

New Jersey Orthopaedic Society

March 17 Bernard A. Rineberg, M.D.

New Jersey Society of Pathologists

January 20 Frank Campo, M.D., Vice-President
February 17 Frank Campo, M.D., Vice-President
March 17 Frank Campo, M.D., Vice-President
April 14 Frank Campo, M.D., Vice-President

New Jersey Society of Physical Medicine and Rehabilitation

February 17 Robert Iskowitz, M.D., Member-at-Large
March 17 Robert Iskowitz, M.D., Member-at-Large
April 14 Robert Iskowitz, M.D., Member-at-Large

New Jersey Psychiatric Association

March 17 John C. Patterson, M.D.

Radiological Society of New Jersey

February 17 Gilbert S. Melnick, M.D., President-Elect

New Jersey Rheumatism Association

February 17 William E. Ryan, M.D., Liaison
March 17 William E. Ryan, M.D., Liaison
April 14 William E. Ryan, M.D., Liaison

New Jersey Chapter, American College of Surgeons

February 17 Ames L. Filippone, Jr., M.D., Secretary
March 17 Anita Falla, M.D., President

The Academy of Medicine of New Jersey

January 20 Sherman Garrison, M.D.
February 17 Sherman Garrison, M.D.
Mr. Charles J. Heitzmann,
Executive Director
March 17 Sherman Garrison, M.D.
April 14 Sherman Garrison, M.D.
Robert S. Rigolosi, M.D., President
May 1 Sherman Garrison, M.D.

Medical Society of New Jersey Auxiliary

February 17 Mrs. William Gellman, President
March 17 Mrs. Bernardine Moloney, President-Elect

American Society of Cytology

February 17 Carolyn W. Watson, M.D., Alternate
Delegate
March 17 Carolyn W. Watson, M.D., Alternate
Delegate

in the assignment program, and **wish to withdraw, you must notify the carrier (Prudential) in writing by September 30, 1985. Certified mail is suggested. If you participate in more than one state, all carriers must be notified.**

PATIENT INFORMATION BROCHURE ON PROFESSIONAL LIABILITY

A new pamphlet answering patient questions on professional liability and malpractice now is available from the American Medical Association.

The brochure, a useful handout for all patients, explains the cost of medical liability and what physicians

are doing about the problem.

The pamphlet entitled, "Doctor, Why Am I Hearing So Much about Professional Liability and Malpractice Today?" can be ordered from the AMA in packets of 100; each packet is \$10 with a 10 percent discount for members. To order please write, American Medical Association, P.O. Box 10946 Chicago, IL 60610, publication number OP 193.

FINI

"Success is not a destination. It's a continuing effort."

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presents

PREP FOR PRACTICE

A PRACTICE MANAGEMENT SEMINAR FOR RESIDENTS

SATURDAY, NOVEMBER 2, 1985

9:00 A.M.-4:30 P.M.

at the Executive Offices of the
MEDICAL SOCIETY OF NEW JERSEY

Lawrenceville, New Jersey 08648

MORNING PROGRAM

9:00-9:15	Introduction
9:15-10:00	Search for the Right Opportunity • How the Changing Complexion of Health Care Will Affect You • Professional Consideration in Selecting a Site • Personal Considerations • Financial Considerations
10:00-10:15	Questions and Answers
10:15-11:15	Types of Practice • Solo • Partnership • Group • HMOs
11:15-11:30	Questions and Answers
11:30-12:00	Physical Facilities • Space Requirements • Floor Plans • Patient and Work Flow
12:00-12:15	Questions and Answers
12:15-1:00	Lunch

AFTERNOON PROGRAM

1:00-1:30	Business Insurance • Types • How Much and When
1:30-1:45	Questions and Answers
1:45-2:30	Personnel • What You Need • How to Find • Job Descriptions • Performance Reviews and Salary Reviews
2:30-2:45	Questions and Answers
2:45-3:15	Systems • Time Management • Charts and Records • Phones • Billing, Insurance and Collection • Fees • Medicare
3:15-3:30	Questions and Answers
3:30-4:15	Financial Management
4:15-4:30	Questions and Answers
4:30	Adjournment

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Two Views on the Malpractice Insurance Crisis

Both sides of the medical malpractice insurance issue are discussed.

A view from the opposition.† The medical industry once again is raising a hue and cry about a medical malpractice crisis, just as it did a decade ago. Health care providers are asking state legislatures across the land to enact special interest legislation to protect them from the consequences of their own negligence. Once again, some of the most powerful economic and political forces in America are knocking at the door of opportunity, and, once again, health care consumers undoubtedly will be outspent in the political battle over their legal rights. And, finally, the primary protection citizens have against this medical-insurance-political juggernaut is truth.

Then years ago, when the medical malpractice insurance industry first cried wolf, citizens who opposed the proposed radical legal changes had little evidence with which to work. Insurers were not required to report medical malpractice as a separate line of insurance until 1975, far too late to prevent special interest legislation from being passed in every state in the Union during the mid-1970s.

The story now is different. We nearly have a decade of experience and information upon which we can base our policy decisions. What is vital is that we, the public, public officials, and the media, take advantage of this experience and take a hard look at the facts. The stakes are too high for us to be fooled again.

THERE IS NO MEDICAL MALPRACTICE INSURANCE CRISIS

What is a "crisis in insurance"? "Crisis" is a very strong word. It cannot mean simply that things are

more expensive than they were yesterday. It cannot mean that a corporation is not expanding as fast as it might. It cannot mean that an individual's income, though very, very high already, could be higher. Yet, proponents of the medical industry's special interest legislation would argue that "crisis" can be defined as all of these, and more.

Unlike the mid-1970s, there is no claim this time of lack of availability of medical malpractice insurance. The AMA's roundtable on medical malpractice makes that clear: "Availability doesn't seem to be a problem,"¹ "[I]t's not comparable to the mid-1970's crisis in availability..."²

The claim, then, is that there is a "crisis" because malpractice insurance costs too much, is getting more expensive all the time, and is driving up the cost of health care. Furthermore, the argument goes, fear of malpractice claims is forcing doctors to practice "defensive medicine," defined as health care undertaken primarily in response to fear of litigation. Let's look at the facts.

1. Medical malpractice insurance premiums are less than one-half of 1 percent of health care costs. Since 1976, the cost of malpractice insurance actually has been declining steadily as a percentage of total health care costs, until it now, at \$1.5 billion in 1983,³ is less than one-half of 1 percent of total health care costs (\$355.4 billion).⁴ Put another way, medical malpractice premiums actually have declined by 45 percent as a percentage of health care costs. Even the insurance industry's estimates of incurred loss and loss expense payments have remained quite constant at the one-half percent mark (\$1.69 billion).⁵

The cost of malpractice insurance is not only low when compared to the cost of health care, it is low in absolute terms: in 1983, the average American spent nearly \$1,500 on health care;⁶ of that, only \$6.08, or 11 cents a week, went to malpractice insurance premiums.⁷

2. Medical malpractice insurance companies are profitable, even if they won't admit it. Part of the so-called "crisis" in medical insurance is alleged to be the insurance companies' inability to keep far enough ahead of escalating losses to make a profit. In its first report in the highly publicized series of three, the AMA Task Force demonstrates a lack of understanding of how medical malpractice insurers make money. In that report, the Task Force focuses on the insurance industry's "estimate of incurred loss and loss expense payments" as an indicator of profitability of the industry. What it fails to mention is that a particularly important component of profitability of malpractice insurers is investment income. Malpractice insurers pay claims relatively slowly: for the occurrence years 1978 to 1983, the industry paid an average of only 3.6 percent of incurred losses by the end of the first year, 9.6 percent by the end of the second year, and 19.0 percent by the end of the third year.⁸ Meanwhile, the assets en-

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Director of Special Projects.

†This essay was prepared as a release by Thomas G. Goddard, Public Affairs Department, Association of Trial Lawyers of America, to its membership, press, and legislators.

cumbered by reserves (measured by the difference between what the insurer has paid and the estimate of incurred loss and loss expense payments) earn investment income at a rate in excess of 10 percent.⁹ For the six occurrence years from 1978 through 1983, the medical malpractice insurance industry earned approximately \$300 million more in investment income on assets encumbered by reserves than it paid to victims (\$1.761 billion in investment income¹⁰ as opposed to \$1.465 billion in losses paid).¹¹ When one considers that those companies also earned \$7.344 billion in premiums,¹² it becomes evident that malpractice insurers are doing better than they would have the public, or the doctors they insure, believe.

In fact, on several occasions, doctors successfully have sued their insurance companies for overcharging or anticompetitive business practices. The California Supreme Court ordered a rebate to 5,000 California physicians of \$9,200 to each—more than four times the average premium paid during the year of the overcharging.¹³ These claims of malpractice insurance overcharging have not subsided with the passage of time—on February 26, 1985, a group of New York physicians filed suit against the Commissioner of Insurance, challenging a recent order raising malpractice premiums of one company in that state.¹⁴

3. The average doctor pays a very small percent of gross income for medical malpractice insurance. Clearly, the cost of medical malpractice insurance is not a burden on the average citizen, particularly compared with total health care costs. But is that cost a burden on physicians? The answer is, by and large, no. The average American physician spends only 2.9 percent of his or her gross income (currently estimated at around \$200,000) on medical malpractice insurance.¹⁵ This is just slightly more than the 2.3 percent spent on "professional care upkeep," but, interestingly enough, well over the 1.2 percent spent on continuing education.¹⁶ In fact, an examination of U.S. Census Bureau statistics relating to the growth in the number of physicians in the United States indicates that the average premium per physician actually declined from 1977 to 1981 by 6.5 percent.¹⁷ Obviously, some physicians spend a greater percentage of their gross income than 2.9 percent on malpractice premiums, but even neurosurgeons, who pay the highest percentage of gross income of any specialty, are spending only 5.8 percent.¹⁸ The very high premiums that are publicized are very rare—57 percent of doctors spend less than \$5,000 on malpractice premiums, while only 12 percent spend over \$15,000,¹⁹ with these highest premiums being paid by those well-paid surgical specialists whose work constitutes the greatest risk of harm to health care consumers. In short, as New York trial lawyer Richard Shandell put it recently, a New York City doctor, who pays the highest premiums in the country, pays a smaller percentage of his gross income on liability insurance than does a New York City cab driver.²⁰

4. Defensive medicine merely is careful medicine. Advocates of radical restrictions on the rights of health care consumers argue that it is the cost of defensive medicine which bears the true price tag of the so-called medical malpractice insurance "crisis." The first question that must be answered is, "What is defensive

medicine?" There is no consensus on the answer to that question. As it was once put, "What might appear to be defensive medical practice to one clinician may, to another, be quality medical care."²¹ One report has concluded that, while increased electronic fetal monitoring and cesarean sections probably were caused by the growing number of suits around fetal injuries, those procedures did increase the survival of newborn babies.²² As it was put recently by a representative of the American Medical Association before a Kansas Citizens' Task Force on Medical Malpractice, defensive medicine is too nebulous a concept to serve as the basis of tort restrictive legislation.

It also should be noted that defensive medicine not only can cost money, but also can save money. It is a common characteristic of first-party health insurance plans to require a second opinion as a prerequisite to full compensation for a surgical procedure. Both the uncertainty of definition and the uncertainty of economic impact of defensive medicine call into question the medical industry's claims.

One of the distressing things about the medical industry's claims that the threat of litigation forces health care providers to provide unnecessary treatment is that it is a violation of the medical profession's own ethical code to "provide or prescribe unnecessary services."²³ Surely physicians cannot expect the public to believe that this decidedly minuscule economic burden of medical malpractice insurance would lead a significant number of physicians to violate such a clear ethical mandate.

Even if one could define defensive medicine so as to distinguish careful practice from unnecessary surgery, and second, if one were to accept as true the American Medical Association's top estimate of the so-called "cost of defensive medicine," that cost works out to be \$1.19 per week for the average American. Where is the crisis?

In short, to the extent "defensive medicine" constitutes improved health care (sponge counts, fetal monitoring), it must not be discouraged. To the extent it constitutes unnecessary treatment, it is unmistakably unethical, and cannot be excused by claims that the burden of malpractice insurance (remember, that's 0.42 percent of health costs and 2.9 percent of physicians' incomes) drives health care providers to practice it.

5. Health care costs are causing increased malpractice costs, not the other way around. The irony of the argument that medical malpractice costs are driving up the cost of health care is that the contrary is probably more accurate: because a very large percentage of medical malpractice verdicts are to pay for past and future medical care, it is in fact the rising cost of health care which has prompted juries to award higher verdicts.

THE CAUSE OF MALPRACTICE LITIGATION IS MEDICAL NEGLIGENCE

Every study that has examined the question of what percentage of instances of medical negligence result in the filing of malpractice claims has concluded that there is substantially more medical negligence than there are malpractice suits. A study included in the Report of the Secretary's Commission on Medical

Malpractice revealed that only 1 in every 15 severe injuries resulting from medical negligence led to malpractice claims.²⁴ Similarly, a Rand Corporation study found that "at most 1 in 10 incidents of malpractice result in a claim, and of these, less than half, or 1 in 25, receive payment."²⁵ It should be no surprise that medical negligence is the primary cause of malpractice litigation. Testifying before the U.S. Department of Health, Education and Welfare Commission on Medical Malpractice, Eli Bernzweig, former president of Argonaut Insurance Company and the Commission's Executive Director, concluded: "The time has come for all parties seeking solutions to the malpractice problem to recognize that the root cause of the current malpractice problem is the substantial number of injuries and other adverse results sustained by patients during the course of hospital and medical treatment."

That conclusion is no less true today than it was in 1975. Yet the American Medical Association, in the "Action Plan" released on February 14, 1985, by its Special Task Force on Professional Liability and Insurance proposed four general categories of "solutions:" public relations, special interest legislation, improving the medical industry's "defense capability," and, lastly, risk control and quality review.²⁶ That the AMA should place quality review last among its proposals should not be surprising: the medical professions historically do not adequately discipline their own members. A couple of examples illustrate this point. For example, in the state of Washington, with over a 30 percent increase in the number of licensed physicians between 1976 and 1981 and an approximate 400 percent increase in the number of referrals to the State Medical Disciplinary Board, not one physician's license was revoked in 1981.²⁷ During the late 1970s, one Florida doctor accounted for 31 paid claims—he is still practicing medicine in that state, never sanctioned.²⁸ These are not isolated instances, according to a report issued by the Oversight and Investigations Subcommittee of the United States House of Representatives Committee on Interstate and Foreign Commerce. One of the findings of that report was that professional standard review organizations entrusted with the responsibility of measuring care at hospitals were not fulfilling their responsibility.²⁹

encouraging the safe practice of medicine by permitting consistently negligent physicians to spread their risk of error among their more careful fellow doctors.³¹ These "repeaters" have a substantial impact on losses paid. A closed claims study released in 1983 by Florida Insurance Commissioner Gunter revealed that, from 1975 through 1982, a group of "repeaters" comprising only 0.7 percent of the total number of Florida physicians were responsible for 24 percent of the claims in which indemnity payments were made.³² A four-year California study demonstrated that the Florida figures were not a fluke: 0.6 percent of the 8,000 Los Angeles area physicians studied accounted for 10 percent of all claims and 30 percent of all payments.³³

THE PROPOSALS OF THE MEDICAL INDUSTRY ARE SIMPLY SPECIAL INTEREST LEGISLATION

The proposals of the medical industry to restrict the rights of health care consumers are nothing more than special interest legislation. That industry asks that a special niche in American law be carved out for doctors, while the rest of us are held responsible for our carelessness under time-tested rules of law. The "need" for this special protection from traditional American principles of responsibility does not even relate to the technical or scientific nature of the medical profession: the standard of care required of physicians is established by the medical profession itself. A doctor cannot be held negligent unless his conduct falls below the minimum level of care considered acceptable by other doctors in the same field of practice. Yet this standard is not reasonable enough for the medical industrialists. They propose a wide variety of methods to prevent victims of medical carelessness from obtaining full compensation for their injuries. What follows is an analysis of a few of these proposals to further insulate doctors from the consequences of their carelessness.

1. Limitations on damages. The AMA would restrict a medical negligence victim's right to recover damages for pain and suffering and a variety of other so-called "non-economic" damages. Other versions of this proposal currently under consideration in some states would limit damages of all kinds to a rigid amount. Any version of this proposal amounts to an effort to shift the costs of medical negligence to the very group of

The cost and availability of medical care may suffer if something is not done to revamp the legal system and curb runaway costs.

In light of the poor record of the medical profession in terms of disciplining those few, repeatedly careless doctors it is that much more important that we preserve the present system. As one study by the Rand Corporation pointed out: By finding fault and assessing damages against the negligent provider, the system sends all providers a signal that discourages future carelessness and reduces future damages.³⁰

In fact, the way medical malpractice insurers have generally set premiums, i.e. by specialty groupings as opposed to by the experience of individual physicians, has decreased the efficiency of the system in terms of

people who need compensation the most: the brain-damaged children, quadriplegics, and other acute victims of medical carelessness. This division of society into classes, seriously injured persons versus less seriously injured persons, victims of medical carelessness versus victims of the carelessness of ordinary citizens, is so antithetical to basic concepts of American justice that such classifications have been held unconstitutional by courts in two-thirds of the states where a court of record has ruled on the issue.³⁴ What is fair compensation for the permanent loss of the use of a child's brain? How do you determine the damages

for the permanent loss of sight? How do you compensate for a permanent inability to walk? These are tough questions, but questions which American juries decide every day in this country in cases brought by victims of drunk drivers, defective products, and a limitless variety of other cases involving human carelessness. The burden clearly is upon the medical industrialists to tell us why their lack of caution should be exempt from this level of scrutiny—a burden they clearly have not carried.

2. Immunity of doctors from punitive damages for malicious, immoral, wanton, willful, or reckless acts. For the ordinary citizen, the law recognizes that there are certain acts which are so outrageous that they merit punishment, but not quite bad enough that they merit criminal prosecution. In those cases, where the victim can show that the defendant acted recklessly, maliciously, wantonly, willfully, or immorally, most courts allow punitive damages to be awarded. The AMA now is asking legislatures to provide special protection for those members of the medical profession who act in such an outrageous manner. The unusual aspect of this request is that punitive damages are extraordinarily rare in medical malpractice cases. For example, in 1984, for the first time in the history of the state, a Kansas jury awarded punitive damages in a medical malpractice case. Again, this proposal is simply another request for special privileges for a group of people who do not need them.

3. Government-imposed restrictions on attorneys' fees. One of the arguments most frequently raised by proponents of special interest legislation for hospitals and doctors is that trial lawyers are encouraged to bring "frivolous" malpractice suits because they are customarily paid on the contingency fee system. In that system, the attorney receives no fee unless and until he obtains an award for his client, and his fee is based on a percentage of that award (usually one-third). To deal with the supposed problem, the medical industry is proposing that government step into the contractual arrangement between victim and lawyer and dictate the terms of that private agreement. In fact, the contingency fee system makes the frivolous suit less likely: The lawyer who is paid a contingency fee ... is not likely to invest time and several thousand dollars in out-of-pocket expenses on a case with little prospect of success. Under the system of contingency fees, lawyers thus have the incentive to filter out capricious suits, which otherwise would overload the courts, harass physicians, and produce no social benefits.³⁵

Another justification given by the medical industry for this proposed intrusion on a citizen's right to contract is that limiting contingent fees is an effort to increase the amount of money actually paid to the medical negligence victim. One need only answer the following question to test the sincerity of that claim: How many of us could afford to hire a lawyer on an hourly basis to pursue a negligence case against the vast resources of an insurance company in a case which might require the expenditure of tens of thousands of dollars just for expenses (costs of expert witnesses, investigation fees, and even photocopying voluminous hospital records), not to mention lawyers' fees ranging from \$80 per hour to \$300 per hour? Very

few of us could even start such a case (especially if we were unable to work as a result of injuries), and, for those who could, maintaining an action against an economic entity with seemingly endless resources would be very difficult at best.

A Rand Corporation study, commissioned by the United States Department of Health, Education and Welfare, which examined all claims of advocates of limits on contingency fees concluded that any restriction on those fees would be inappropriate.³⁶ No, the proponents of this brand of special interest legislation are not trying to stop frivolous lawsuits, they are not trying to increase payments to victims. They are simply trying to prevent victims of medical negligence from pursuing their legitimate claims. Nothing more, nothing less.

4. Elimination of the collateral source rule. The AMA proposes that states abolish the collateral source rule. This is an important rule of law in most states which prevents a person found to be guilty of negligence from reducing the amount he owes his victim by the amount which the victim has received from other sources, like health insurance or government benefits. Once again, the proponents of this legislation want to shift the costs of carelessness away from the careless and to the innocent victim, who paid for his health insurance, the innocent employer of the victim, who paid for the victim's group insurance, or the innocent taxpayer, who paid for the government benefits. The injustice of this proposal is evident on its face.

CONCLUSION

There is a medical malpractice problem. It is too much medical malpractice. As James S. Todd, M.D., Diplomate of the American Board of Surgery and a Trustee of the American Medical Association once said, "Efforts directed toward tort reform and legislative relief must be reasonable and not self-serving. Malpractice is a medical problem, not a legal one, and those injured as a result of negligence are entitled to fair and prompt compensation...."

It is time for all the parties in this very important issue to stop the baseless cries for legislative relief, and to sit down and get serious about protecting the most important consumer—the health care consumer. After all, we are all potential victims. We all have a stake in the outcome.

REFERENCES

Available upon request.

COUNTERPOINT

The following was prepared by the AMA in response to anticipated adversarial comments regarding malpractice.

It is vital that the public know about medicine's efforts to restrain the spiraling number of lawsuits and to reduce the cost of insurance. Our efforts benefit patients as well as physicians. If the current medical malpractice crisis—really a crisis of professional liability—were only a "pocketbook" issue for physicians, it wouldn't qualify as a crisis. But the current situation directly affects the cost and availability of medical care for all Americans.

Here's how: Americans are filing three times as many

claims as they did ten years ago and they're receiving record awards. Many doctors pay anywhere from \$20,000 to \$80,000 a year for liability insurance, which is partially passed on to patients in the form of higher charges for office visits and treatment. Indeed, insurance is the fastest growing part of physicians' expenses. But that isn't the only factor fueling the high cost of health care.

Because of the "sue 'em" society in which we live today, physicians are forced to practice what is called "defensive medicine," the ordering of additional tests and treatment primarily for protection in the event of a lawsuit. That, too, pushes up the cost of medical care.

Rising premiums and the threat of court actions are forcing many able doctors to retire early, to refuse to perform high-risk services, or not to enter certain high-risk specialties.

There is no evidence to show that the higher number of claims and the ballooning size of awards are related to a decline in the quality of medical care. On the contrary, the crisis is caused to some extent by the greatly improved quality and possibilities of modern medicine. Unfortunately, those improvements in medicine have generated the unrealistic expectation that every treatment or service will produce perfect results. In fact, while medical technology offers improvements in care, it entails greater risks, too. Medicine is a complex, inexact science and patients respond differently to treatment. As such, many liability claims involve no

negligence at all, just unfulfilled expectations.

Negligence does occur, of course, and there is a small number of incompetent physicians. As doctors, we continually work to improve the practice of medicine and to find and discipline physicians whose practice does not measure up to the profession's high standards.

But better quality control alone will not eliminate this problem. The AMA's Task Force on Professional Liability and Insurance addressed the crisis through an action program, which offers several recommendations. Among them is a program in which the AMA urges physicians to be alert to procedures and to other doctors not conforming to high standards of care. The AMA is committed to work with various other organizations toward expanded and vigorous self-regulation and peer review.

But the starting point must be made with our state laws and judicial system. They need to be reformed so that cases without merit are not in the system, legitimate claims are resolved fairly and quickly, and realistic awards are given to injured parties and not to lawyers. There is something inherently wrong with a system that leaves only one-third of the doctor's premium dollar for the injured party.

None of these reforms can be accomplished without the help of the public. This problem affects everyone, not just physicians. The cost and availability of medical care may suffer if something is not done to revamp our legal system and curb these runaway costs.

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Our Health Care System Is Under Fire*

STANLEY S. BERGEN, JR., M.D.

Dr. Bergen, the recipient of the Ill Award, comments on the crisis in the health care system.

When one's peers and colleagues choose you for an award, it is a special honor. When people you respect for their friendship, sincerity, commitment, and dedication—just plain good people—voice their approval, it makes one feel rewarded. When those with whom you work, have worked, debated, and even experienced controversy, join together for an evening, that is an experience that will be cherished and not ever forgotten.

I join an illustrious group of New Jerseyans honored by The Academy of Medicine of New Jersey. That makes me proud because I am proud to be from and still a part of New Jersey. It truly is I who am honored tonight by the list of the company I keep.

Donald Rumsfeld, speaking at Princeton University, noted that his failures were too many to list and therefore it was easier to encompass his few successes in the introduction of him as a speaker. I feel much like Mr. Rumsfeld. Luckily, each of you know only a few of my mistakes; however, I am fearful that time will allow you to compare notes. My errors of choice, decision, and leadership may bring the first-ever request for a return of the Edward J. Ill Award and a striking of the name of the recipient for 1985, an event that will require difficult explanation at future awards dinners.

Current systems under fire include the education of the health care professionals and provision of health

care to people. It brings to all of us a need for responsible thought and decision. Our system now is being questioned from within concerning its quantity, not its quality. Our system is feeling pressures of reduced federal subsidies and pressures of people, industry, and business who have said "enough is enough!" Cost is a factor. Many political leaders sincerely believe the nation can do as well, if not better, with less in resources and more prudent choices to maintain quality. They believe we can serve the less fortunate, continue the health care system that we have developed in the United States, and continue successful research and technology development while we retrench, reallocate, promote prevention of disease, develop new forms of health care delivery, and extend health care education to all the public.

That is the challenge health care professionals must face and accept. We know what is good health care. We recognize quality and ethical judgment. We must pursue what is best for the community and our patients and be cognizant of new factors in a changing environment.

History will judge all of us by the way we address and solve these new problems. If we allow the competitive environment to turn us against one another, if we allow economic change to direct our energies to subversion of our role and trust, if we use surreptitious ways to "beat the system," and, therefore, abdicate our responsibility to our patients, we do not warrant the continued position and status that we have enjoyed in our communities. We are under pressure from within and without. Our response will be equated with our future position in society—one of continued honor or one of fallen grace.

No one forced any of us to become physicians, dentists, or health care professionals. We took on these roles by free choice and we have enjoyed both unparalleled community support in the form of subsidies to education, research, and practice and the provision of health services, while limited very minimally by income restrictions, geographic location, or status rewards. Like a marriage, it was for better or worse and until now our generation has had the best.

Society's demands, even for public service, have been modest to nonexistent. We now must fulfill those expectations the public has established and earn again the honored stature willingly rendered to us. The benefits we have reaped must now be shared as never before in our careers. I know that physicians, dentists, and all health professionals have the capacity to respond; we have before and we can again, despite the unusual and different nature of the challenge.

Thank you for this honor; it is an honor for UMDNJ. It signifies to me that the University has come of age and that the many, many people who have contributed to its growth and success are being honored through me. The Edward J. Ill Award is one of those events that makes one forget previous difficulties and frustration. Your support has made it possible and continues to make it an honor and pleasure for me to be part of New Jersey and part of UMDNJ.

*These remarks were made at The Academy of Medicine of New Jersey Awards Dinner where Dr. Bergen was the Edward J. Ill Award recipient. Dr. Bergen is President of UMDNJ.

AVIAN ANTIGEN

Avian antigens from household birds often are overlooked as the cause of allergy. RAST tests and peak expiratory flow measurements established the diagnosis and convinced the patient to remove the offending parrot.

Estimates suggest that there are more than 25 million birds in America's households. Expensive exotic birds such as the Amazon blue-fronted parrot, the hyacinth macaw, the African peach-faced lovebird, the Philippine golden-backed hanging parrot, the Australian roseate cockatoo, the turquoise parakeet, and the South American toucan legally are imported into Miami at an average rate of 62,000 per month. According to the U.S. Department of Agriculture, only about 10 percent of the birds are purchased at the point of entry; the remainder are disseminated across the United States.¹ In addition, numerous birds are smuggled into the country, adding to the increasing avian population. It has become fashionable and expensive to own an exotic avian pet; prices range from \$50 to \$20,000 depending on the species, training, and scarcity.

The following case illustrates how these increasingly ubiquitous pets may be an unrecognized cause of wheezing and asthma.

CASE REPORT

A 30-year-old white female had a history of tightness in her chest accompanied by wheezing for approximately 2 years. The wheezing was worse at home and subsided during away-from-home vacation periods. A weekend visit at a friend's house also improved her symptoms. Asthmatic symptoms were not induced by cold air, exercise, laughing, or large meals.

She smoked 20 cigarettes per day for approximately 15 years. There was no history of allergic rhinitis, urticaria, or eczema. She had obtained an Amazon parrot approximately 4 years prior to developing breathing difficulties. Family history was negative for asthma and allergy. A chest x-ray was reported as normal in 1982.

Initial physical examination was done in the evening after a work day. Blood pressure was 100/70, pulse rate 82/min, and respiratory rate was 16/min. Nasal mucous membranes were normal; chest was clear

without wheezing, rales, or rhonchi. Her peak expiratory flow measured at this time was 500 L/min; nomogram normal was 480 L/min.²

Our initial impression was that the parrot was related etiologically to the patient's symptoms. She denied that the pet caused her significant problems because immediate contact with the animal did not result in any symptoms and this suggestion caused her to burst into tears. To prove that the parrot was the cause of her problems, the patient was provided with a Mini-Wright peak flow meter to measure her pulmonary functions at home and at work.³ Allergen specific IgE Antibody Phadebas RAST for Australian parrot serum, Australian parrot droppings, and parrot feathers was tested. After discussing the fairly obvious results, the patient removed the pet from her environment and has remained free of symptoms since.

RESULTS

Peak expiratory flow measurements (P.E.F.) were affected by environmental exposure and contact with the bird (Table 1). The patient's normal peak flow is 480 L/min. These measurements show the dramatic changes in pulmonary function while at home and at work.

Phadebas RAST results are illustrated in Table 2. The specific IgE antibody levels were extremely elevated for all three antigens: parrot serum, droppings, and feathers.

Precipitins for parrot antigens were not available in any commercial laboratory.

DISCUSSION

Four epidermal constituents of birds may be involved in allergic inhalant problems. The allergens identified include: 1) The fragments of cornified feather sheaths. 2) Feather-vened dander which may include small sub-branches, known as barbules. (Feathers, especially those of the psittacine family including parakeets, cockatoos, and others, are dusted with a fine substance resembling talcum powder which is capable of contaminating entire households.) 3) Cor-



nified epithelium of the bird skin, which can add to the production of airborne inhalant allergens. 4) A lipid-proteinaceous substance is secreted by uropygial or preen glands. The sebaceous material and saliva dry on the feathers along with the protective powdery substances thus creating more airborne inhalant antigens.⁴ Avian allergy can be a complex problem. Our patient had positive specific IgE antibody to all three antigens (droppings, feathers, and serum).

Introduced in 1959, the Wright peak flow meter was established as an accurate yet simple, portable device for the measurement of ventilatory function. The inexpensive meter can be used to distinguish reversible from irreversible airway obstruction, by measuring P.E.F. before and after bronchodilators.⁵

In our case study, environmental exposure significantly affected our patient as evidenced by the Mini-Wright peak flow measurements. The peak flow meter provided a simple and rapidly performed test with no inconvenience to our patient and convinced her that the home environment was the source of her problems.

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CONCLUSION

Avoidance of the avian antigen is the treatment of choice in allergic individuals. As seen in our case report, avoidance and cleansing the home of avian contaminants can cause dramatic improvement and cessation of symptoms.

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TABLE 2
RAST

Australian parrot serum	>17.5 PRU/ml*
Australian parrot droppings	15.5 PRU/ml
Australian parrot feathers	>17.5 PRU/ml
* <0.35 PRU/ml Antibody absent or at undetectable level.	

TABLE 1

PEAK FLOW MEASUREMENTS

	Home 8:00 A.M.	Work 12:00 P.M.	Work 4:00 P.M.	Home 8:00 P.M.
Thursday	380 L/min 420	560 540	500 550	400 440
Friday	440 370	560 580	580 630	300 370
Saturday	530 490	230 220	Home	Not at home
Sunday	Not at home entire day			10:00 P.M. 400 420
Monday	250 250	540 560	560 580	

DIABETES-RELATED LOWER EXTREMITY AMPUTATIONS IN NEW JERSEY, 1979 to 1981

ANDREW D. MILLER, M.D., ARTHUR VAN BUSKIRK, WENDY VERHOEK-OFTEDAHL, M.S.,
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Using New Jersey hospital discharge abstracts, we analyzed diabetes-related lower extremity amputations (LEAs). In 1979 to 1981, an average of 1,448 LEAs were performed. Rate and extent of amputations increased with age.

Amputation is a significant and not uncommon complication of the vascular effects of diabetes. Diabetics account for an estimated 50 to 70 percent of all nontraumatic lower extremity amputations (LEAs).¹ One estimate states between 5 and 15 percent of all diabetics undergo an LEA at some time during their lives.²

However, diabetes-related LEAs also are to a large degree preventable. The National Diabetes Advisory Board has estimated that the number of diabetes-related amputations could be cut in half through professional and patient education and the use of preventive measures.¹ This confidence is based on programs such as that of Lippman, who introduced a foot-care program in a nursing home where the average resident was 86 years old. Before the program was instituted, between 8 and 15 residents underwent LEA each year; no amputations were necessary in residents enrolled in the nursing home program during its first 15 years.³

In order to determine the impact of diabetes-related LEAs in New Jersey and to identify groups at high risk of having an LEA, the Diabetes Control Program of the New Jersey State Department of Health utilized New Jersey hospital discharge abstracts to study diabetes-related LEAs done in New Jersey hospitals in 1979, 1980, and 1981.

MATERIALS AND METHODS

Since 1976, acute care hospitals in New Jersey have been required to submit to the State Department of Health discharge data on every hospitalization using the International Classification of Disease coding system.⁴ These Hospital Discharge Abstract data were used for 1979, 1980, and 1981 to examine the diabetes-related LEAs that were performed in New Jersey hospitals during those years. Data from 1981 and 1982 Uniform Bill-Patient Summaries that have been required for each hospitalization since 1981 also were used.⁵

For the purposes of this study, diabetes-related LEAs were defined as amputations that were reported on a discharge abstract with: 1) a procedure code for lower extremity amputation (ICD-9-CM code 84.11 through 84.17) and 2) a diagnosis code for diabetes (ICD-9-CM code of 250) (Table 1). In order to screen out trauma-related amputations done on diabetics, discharges

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TABLE 1

*International Classification of Diseases
9th Revision—Clinical Modification*

Procedure Code	Description of Procedure
84.11	Amputation of toe
84.12	Amputation through foot
84.13	Disarticulation of ankle
84.14	Amputation of ankle through malleoli of tibia and fibula
84.15	Other amputation below knee
84.16	Disarticulation of knee
84.17	Amputation above knee
Diagnosis Code	Diagnosis
250	Diabetes mellitus

TABLE 2

*Diabetes-Related Lower Extremity Amputations
Performed on New Jersey Residents in New Jersey
Hospitals, 1979 to 1981*

Year	Diabetes LEAs	Percentage of All LEAs*
1979	1257	59
1980	1438	63 [†]
1981	1650	68 [°]
Mean (79-81)	1448	63

*All LEAs include out-of-state residents.

[†]1980 different from 1979 at $P=0.012$ level.

[°]1981 different from 1980 at $P=0.0004$ level.

that had a trauma-related diagnosis were eliminated.

Calculations of rates of diabetes-related LEAs among various groups of diabetics used prevalence data from the 1978 National Health Interview Survey applied to 1980 New Jersey census data.⁶ Differences between the years studied were tested for statistical significance where appropriate.⁶

RESULTS

During the years 1979, 1980, and 1981, an average of 1,448 hospitalizations that resulted in at least 1 diabetes-related LEA were reported annually by New Jersey hospitals, representing a rate of 76.8/10,000 estimated diabetics. These diabetes-related LEAs accounted for 63 percent of all LEAs and 1.9 percent of all diabetes admissions during those three years (Table 2). At least 1 diabetes-related LEA was reported each year by almost every acute care hospital in the state during this time period.

The number of diabetes-related LEAs reported increased 31 percent from 1979 to 1981, from 1,257 to 1,650; in contrast, a 9 percent decrease in nondiabetes-related LEAs was reported over the same period.

Nine percent of the diabetes-related LEAs were repeat amputations performed on the same diabetic during a single year (Table 3). Multiple LEAs performed during a single hospitalization were not considered repeat LEAs. The percentage of repeat diabetes-related LEAs also increased 16 percent from 1979 to 1981, from 8.1 to 9.4 percent of all reported diabetes-related LEAs, although the increase was not statistically significant.⁷

Table 4 shows the number of diabetes-related LEAs by extent of amputation. During the three-year period studied, 30 percent of diabetes-related LEAs were toe complications, 13 percent were disarticulations of the

TABLE 3

Number of Persons Undergoing Multiple Diabetes-Related LEAs

Year	Two Hospitalizations Resulting in LEAs	Three Hospitalizations Resulting in LEAs	Total	Percentage Undergoing Multiple LEAs
1979	90	4	94	8.1
1980	109	8	117	8.9
1981	127	13*	140	9.4 [†]
			Mean (79-81)	8.8

*Includes one individual with four hospitalizations with diabetes-related LEAs.

[†]1981 not significantly different from 1979 ($P=0.26$).

TABLE 4

Extent of Amputation

Year	Toe (%)	Foot (%)	BKA (%)	AKA (%)	All Other* (%)	Total
1979	397 (31.6)	134 (10.7)	421 (33.5)	300 (23.9)	5 (0.4)	1257
1980	435 (30.3)	194 (13.5)	481 (33.4)	314 (21.8)	14 (1.0)	1438
1981	492 (29.8)	235 (14.2)	573 (34.7)	338 (20.5)	12 (0.7)	1650
Mean (79-81)	441 (30.4)	188 (13.0)	492 (34.0)	317 (21.9)	10 (0.7)	1448

*Includes: 84.13 disarticulation of ankle, 84.14 amputation of ankle through malleoli of tibia and fibula, and 84.16 disarticulation of knee.

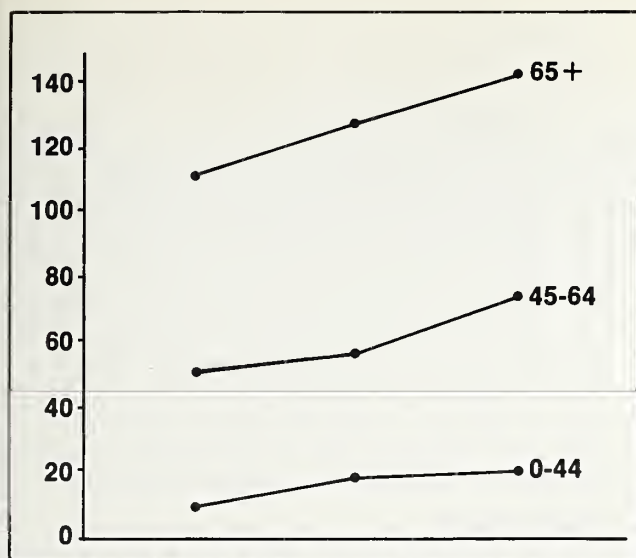


Figure 1—Rate per 10,000 estimated diabetics by age. Seven discharges in 1981 did not list age.

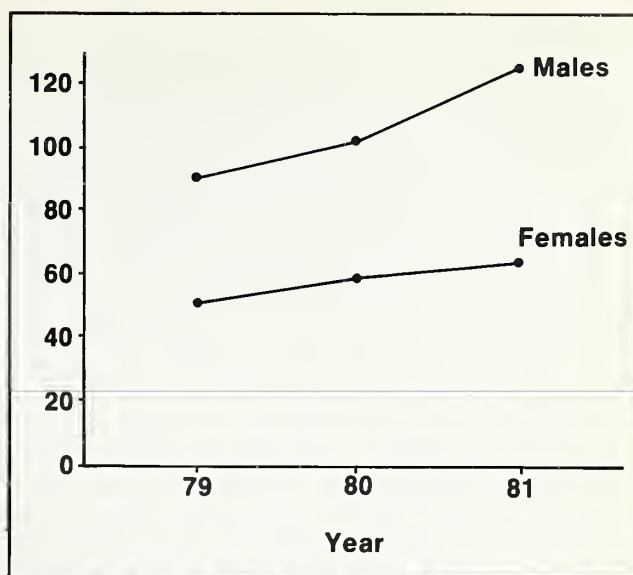


Figure 3—Rate per 10,000 estimated diabetics by sex.

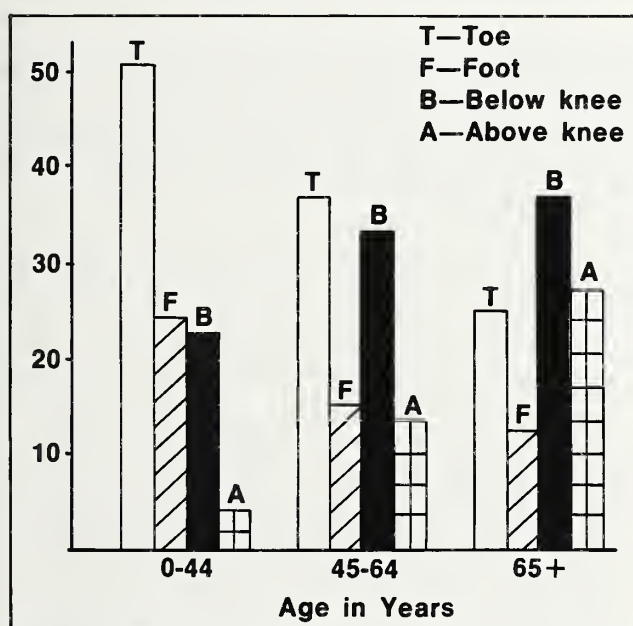


Figure 2—Extent of amputation by age.

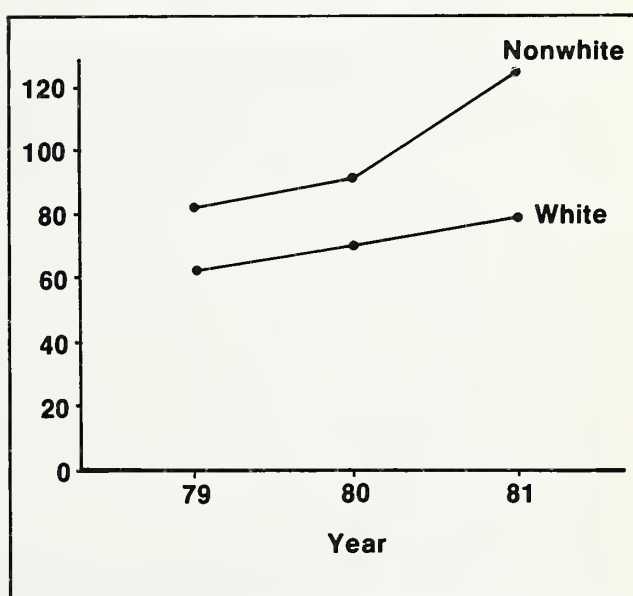


Figure 4—Rate per 10,000 estimated diabetics by race. Twenty-nine discharges in 1981 had no race specified.

ankle, 34 percent were below-knee amputations (BKA), and 22 percent were above-knee amputations (AKA).

The rate of diabetes-related LEAs increased with age during the three-year period studied (Figure 1). The rate for persons in the 45-to-64-year-old age group was 3.4 times higher and the rate in the over 65-year-old age group was 7.1 times higher than that in the 0-to-44-year-old age group. Diabetics 65 years and older accounted for 61 percent of diabetes-related LEAs.

Extent of amputation also increased with age, with a shift from toe amputations to BKAs and AKAs (Figure 2).

The rate of diabetes-related LEAs in males was 1.82 times that of females during the three years studied (Figure 3); nonwhites had a rate 1.38 times higher than that for whites (Figure 4).

The average length of stay for hospitalizations during which a diabetes-related LEA was performed was 40.3 days, accounting for approximately 58,400 hospital days annually. Cost data were not available for the

three years studied, but data from 1982 New Jersey hospital billing information indicate that a total of \$19,670,000 in hospital charges alone was generated by diabetes-related LEAs in that year.

Of all patients who underwent diabetes-related LEAs between 1979 and 1981, 10 percent died while in the hospital. The literature suggests that this figure holds elsewhere.¹

DISCUSSION

Diabetes-related LEAs reflect the considerable morbidity associated with peripheral vascular disease in diabetics. Almost 1 of every 50 diabetes-related hospitalizations in New Jersey results in a LEA; these diabetes-related LEAs account for almost two-thirds of all LEAs reported by New Jersey hospitals each year.

The data presented here include all diabetes-related LEAs performed on New Jersey residents in New Jersey hospitals from 1979 through 1981. However, it is not a complete data set because it does not include am-

putations performed on New Jersey residents in out-of-state hospitals. This information is not available, but it is clear that the numbers presented are somewhat less than the actual number of diabetes-related LEAs undergone by New Jerseyans during those three years.

The number of diabetes-related LEAs reported in New Jersey increased 31 percent between 1979 and 1981, but much of this increase probably is not real. Between 1979 and 1981 a change was made in the ICD coding system, and in 1980 and 1981 about two-thirds of New Jersey's hospitals began to be reimbursed under the DRG system.⁸ The DRG system rewards reporting of all of a patient's diagnoses, and it is more likely under the system that the discharge abstract of persons undergoing an LEA related to diabetes would include a diagnosis code for diabetes. Thus, the reported number of nondiabetes-related LEAs decreased 9 percent from 1979 to 1981, but there is no reason to believe that the actual number of nondiabetes-related LEAs performed decreased.

While differences in reporting probably account for a significant portion of the increase in the number of diabetes-related LEAs reported, some real increase in diabetes-related LEAs may have occurred. The data available do not provide any explanation for this increase, which may reflect a trend toward more aggressive surgical care of diabetes-related peripheral vascular disease.

During the three-year period studied, 9 percent of persons undergoing a diabetes-related LEA underwent a second LEA within the same calendar year, which means that these persons had a repeat amputation within six months on the average (since those diabetics undergoing a LEA late in the year had only a few months in which to have a second LEA). In this study it was not possible to link discharge abstracts from the three years, which would have allowed an examination of the probability of repeat amputation over a longer period of time.

The LEAs reported in New Jersey diabetics were not minor procedures; over half (56 percent) were below-knee or above-knee amputations. The risk of LEA and the chance of undergoing a higher level amputation increased with age. Males were almost twice as likely as females to undergo a diabetes-related LEA; nonwhites were one-third more likely than whites to have a diabetes-related LEA performed. These findings

are consistent with other studies in the literature,² but it is not known if nonwhites have higher rates of diabetes-related LEAs because of genetic, environmental, or socioeconomic factors.

In 1983, Most and Sinnock of the Centers for Disease Control published a study of diabetes-related LEAs based on hospital discharge abstracts from six states; the data were from hospitalizations occurring between 1974 and 1978.² The findings of this study of diabetes-related LEAs in New Jersey are comparable to those from the six other states studied except for the percentage of amputations of the foot. In the Most and Sinnock study, foot amputations accounted for only 4.4 percent of diabetes-related LEAs; in New Jersey, 13 percent of diabetes-related LEAs were of the foot. This difference may be explainable by temporal or regional differences in surgical technique.

CONCLUSION

It should be noted that the cost of diabetes-related LEAs in 1982 represents only hospital charges and does not include the cost of rehabilitation following amputation nor account for pain suffered or the physical and emotional effects of the loss of part of a limb. The Diabetes Control Program of the New Jersey State Department of Health hopes to use the data presented here to prevent diabetes-related LEAs and reduce the burden of this form of morbidity on diabetics.

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CORDLESS TELEPHONE: HAZARD TO HEARING

S. THOMAS WESTERMAN, M.D., AND LIANE M. GILBERT, M.A., SHREWSBURY*

We present a case regarding noise trauma sustained from the use of a cordless telephone. The damage is not in the usual 4000 Hz frequency which is expected by otologists and audiologists, but is in the low- and mid-frequency range (500 to 1500 Hz).

Some users of cordless telephones have developed a peculiar problem, namely sensory neural hearing loss and tinnitus. Complaints have been filed with the Consumer Product Safety Commission by members of the American Academy of Otolaryngology-Head and Neck Surgery.¹ Class action suits have been instituted because over 120 individuals have experienced mid- and low-frequency decreases caused by the mid- and low-frequency, high-decibel output of the ringer.²

The problem arises from models that have the ringer or signaling device in the earpiece. An individual who is holding the telephone to his ear while he is being signaled can receive sufficient noise trauma to cause a permanent sensory neural hearing loss.

At the 117th annual meeting of the American Otologic Society, Dr. George Singleton of Gainesville, Florida, presented 28 case reports of patients who have permanent hearing loss as a result of the use of cordless telephones.² The most frequent hearing loss experienced by these patients was in the mid-frequency range between 500 and 1500 Hz. Many patients had some degree of pre-existing hearing loss from aging, prior noise exposure, or otosclerosis.

CASE REPORT

A 69-year-old male used a portable telephone manufactured by the Uniden Corporation. The patient was

not familiar with the use of the telephone, which had been purchased by his wife prior to their marriage.

The telephone rang, the patient picked up the portable unit, placed it to his left ear and looked down to the base unit. He thought in order to "work" the phone he was to push a button which was designated as the call button. When he pushed the call button, he experienced an excruciatingly loud noise in his left ear which emanated from the portable unit. Pushing the call button actually produced a noise intended to summon the user of the portable phone to it when a call was received on the base unit. He stated that after he heard the "loud screech" he was not able to hear in the left ear for three days. A small amount of hearing subsequently returned, but he still had a substantial hearing deficit. He had no other ear, nose, or throat problems or symptoms due to the above incident, but a hearing loss was discovered by hearing tests taken as part of a routine examination prior to the above incident.

The patient had not taken ototoxic drugs, had no allergies, was never in the service, was never exposed to firearm noise, and did not smoke. He took metoprolol tartrate for high blood pressure. He did use

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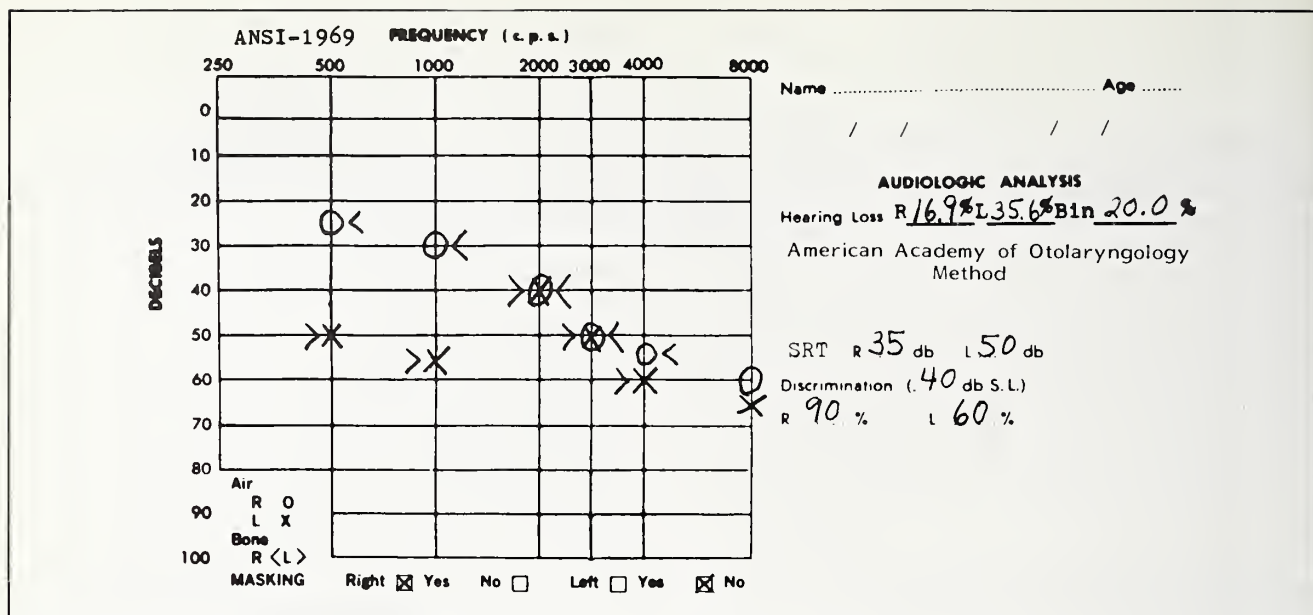


Figure 1—Post-trauma audiologic analysis.

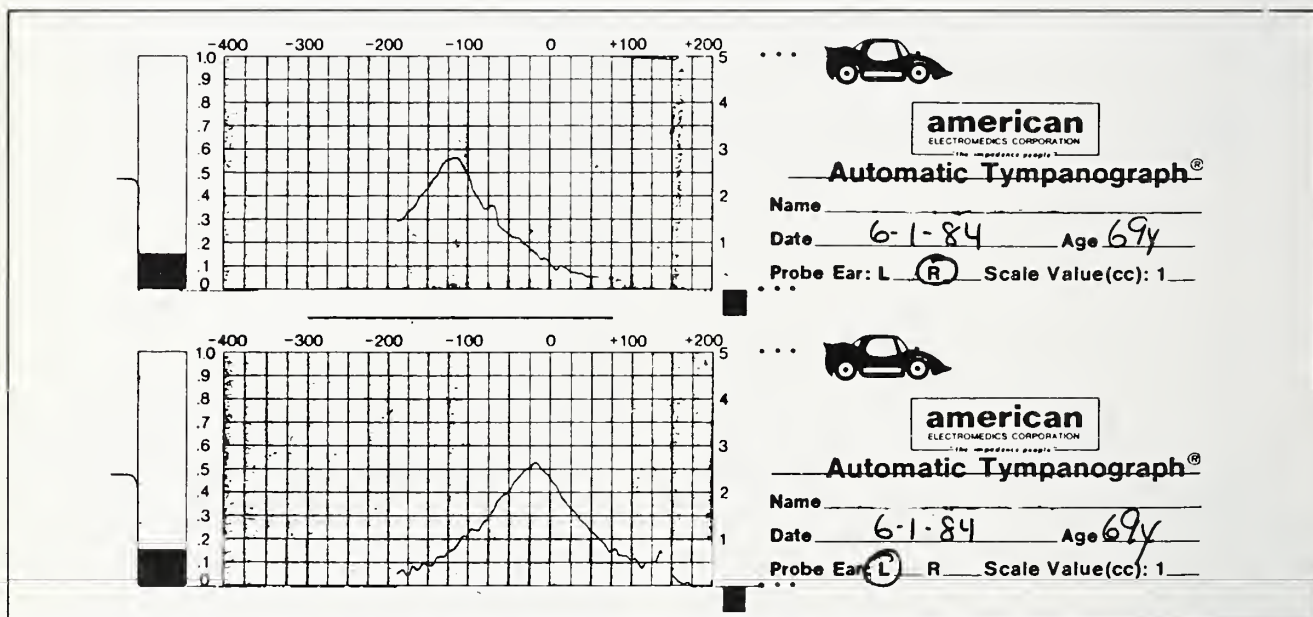


Figure 2—Post-trauma tympanogram.

stereo headsets, but did not turn the volume "too loud."

The patient heard my normal voice during the history interview. Both auricles, external ear canals, and ear drums were normal. Tuning fork tests in the speech frequencies revealed a positive Rinne test binaurally. The Weber test lateralized to the right in the 500 to 1000 Hz frequency and was equal in the 2000 Hz frequency. Air comparison tests revealed much better hearing on the right side than on the left in the 500 and 1000 Hz; they were equal in the 2000 Hz. His hearing appeared borderline with air conduction on the right, with a moderately severe sensory neural hearing loss on the left.

Audiologic analysis then was performed. Using the American Academy of Otolaryngology calculation of hearing handicap of 1979, a 16.9 percent sensory neural hearing loss was present in the right ear with a 35.6 percent sensory neural hearing loss in the left ear,

yielding a binaural sensory neural hearing loss of 20.0 percent (Figure 1).

Discrimination score was 60 percent on the left and 90 percent on the right. Tympanogram revealed a type A tympanogram in the left ear with a type A-C tympanogram and slight negative pressure in the right ear (Figure 2). There was absence of the stapes reflexes binaurally which was compatible with his level of hearing loss.

The Uniden Extend-A-Phone Model 300, which he utilized, then was evaluated.³ The test telephone had a base unit and a handset.

A GenRad Model 1962-9610 was mounted in a tripod 0.1 cm from the center of the handset's earpiece. The handset also was mounted on a tripod. No sound-reflecting surfaces were in the vicinity of the handset or the microphone. The orientation of the microphone was for normal incidence (0 degrees).

The microphone was connected to GenRod Precision

TABLE
*Magnitude and Frequency of the Principal Peak**

Sample Code	Magnitude of the principal peak	Frequency of the principal peak
A	133 dB	753 Hz
B	125 dB	796 Hz
C	121 dB	834 Hz
D	134 dB	737 Hz
E	128 dB	845 Hz

*From Mills R & Toms D: Report of the U.S. Consumer Products Safety Commission, No. 544053, June, 22, 1983.

Sound Level Meter and Analyzer Model 1982 which in turn was used as input to a Nagra 4.2L magnetic tape recorder. The instrumentation system was calibrated using a 1000 Hz tone with sound pressure level of 114 dB. A GenRad Calibrator, Model 1562-A, was used to record the calibration tone on the magnetic tape.

The handset call button was activated by depressing the base station call button. The resulting noise emissions were recorded.

The data on the magnetic tape was analyzed using a GenRod Real Time Analyzer Model 1921 which provided one-third octave band sound pressure level spectrum in the A-weighted sound level. The fundamental tone emitted from the handset speaker was in the 800 Hz band. The level of emission at a distance of 0.1 cm was 121 dB. Two harmonics of the fundamental tone were evident but were of a lower sound

pressure level. The A-weighted sound level of this emission was 121 dB. (Figure 3).

The decibel and frequency levels of five cordless telephones were tested by the Consumer Products Safety Commission.⁴ A Kemar manikin with a large pinna and a modified Zwislocki coupler (manufactured by Industrial Research Products Inc.) was utilized.

All five measurements in the A-weighted curve were from 123 dB to 135 dB. The measured sound pressure levels could be reduced about 20 dB if the remote receiver was held several centimeters away from the manikin's outer ear instead of against it.

The magnitude of the principal peak was between 121 to 133 dB and the frequency of the principal peak was between 737 Hz through 845 Hz (Table).

COMMENT

This individual's experience was compatible with the experiences of others receiving a similar sudden blast of noise to the ear from a cordless telephone. The frequencies involved in the noise damage were lower than the usual 3 to 6 kHz involved with noise trauma.

This unusual set of circumstances makes it imperative to immediately warn individuals utilizing cordless telephones of the dangers involved, and to make certain that future handsets are modified so that the "call" sound is not in the receiver.

Dynascan, a Chicago firm, and Uniden cordless telephones distributed by AT&T have redesigned their products taking the ringer out of the earpiece.⁵

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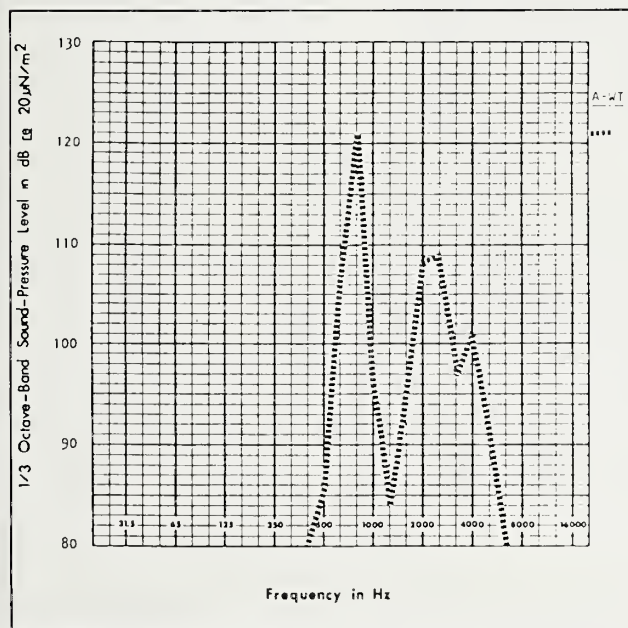
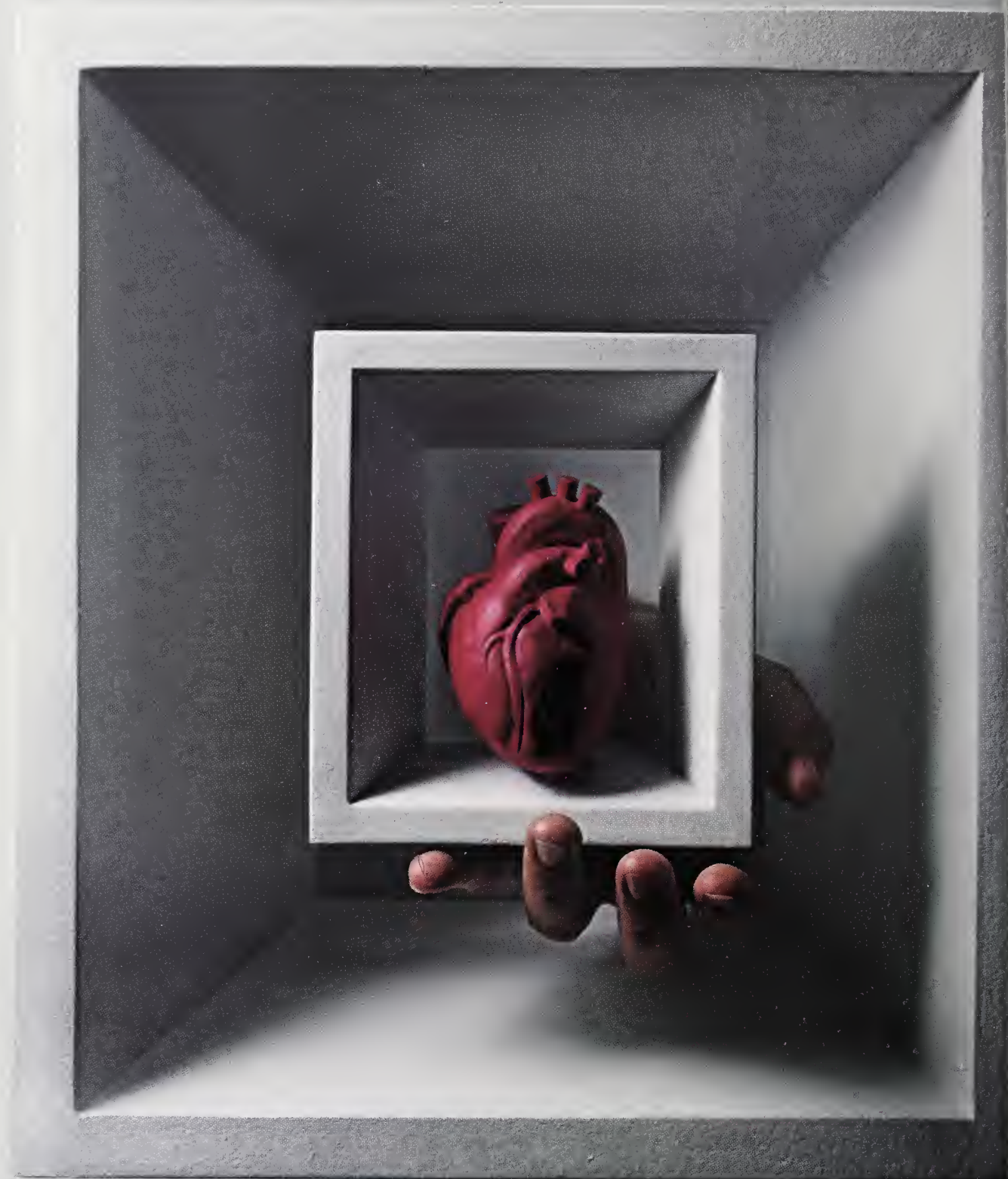


Figure 3—One-third octave band sound pressure level spectrum of the noise emitted from the handset of a Uniden Extend-a-Phone Model 300 when the call button on the base unit is depressed. Microphone distance from handset is 0.1 cm.



CASE REPORT: STERNOCLAVICULAR PYARTHROSIS

WILLIAM E. FARRER, M.D., ELIZABETH*

A patient presenting with Staphylococcus aureus sepsis was found to have sternoclavicular arthritis. Diagnosis and treatment of sternoclavicular infections are discussed.

Infection of the sternoclavicular joint is relatively uncommon, being reported in from 0 to 6 percent in three recent series of nongonococcal infectious arthritis.^{1,3} It often is indolent and subtle in presentation; delays in diagnosis are frequent. A case presented at the Northern New Jersey Infectious Disease Rounds illustrates some of the problems in diagnosis and the treatment of this condition.

CASE REPORT

A 66-year-old man was in good health until six days prior to admission when he "hurt his back" while lifting a heavy object at work. He was treated with analgesics, but a few days later noted sore throat, fever, and chills as well as a slightly tender mass in the right upper anterior chest wall. He was admitted to St. Elizabeth Hospital because of increasing fever and confusion.

Physical examination revealed a febrile (101°F), lethargic white male in no acute distress. Pulse rate was 98/min; blood pressure was 130/84 mm/Hg; respirations were 20/min. The sclerae were slightly icteric but the fundi were negative. Neck was supple; there was no lymphadenopathy. A few rales were heard at the left lung base. No cardiac murmurs or rhythm disturbances were noted. The abdomen was negative. There was a splinter hemorrhage in the right middle finger and two petechiae were on the tip of the right

thumb. Overlying the head of the right clavicle was a soft tissue mass which measured several centimeters in diameter. It was slightly tender, but not reddened or fluctuant.

Laboratory data included the following: white blood cell count, 16,600/mm³ with 90 percent polymorphonuclears, 9 percent lymphs, and 1 percent monocytes; Hct, 43; platelets, 207,000; glucose, 154; alkaline phosphatase, 183; total protein, 7.0; albumin, 3.4; bilirubin, 2.6; SGOT, 44; LDH, 265; and creatinine, 1.6. Urine sediment contained 5 to 10 WBC per high power field and gram-positive cocci in clusters. Chest x-ray showed a patchy infiltrate at the left base.

The patient's pneumonia was treated empirically with ampicillin and tobramycin. In view of the elevated alkaline phosphatase and jaundice, acute cholecystitis also was considered. Aspiration of the chest wall lesion yielded only a few drops of bloody fluid which was culture negative. On day three, both sets of blood cultures drawn on admission were reported to be positive for *Staphylococcus aureus* and later were found to be sensitive to oxacillin but resistant to penicillin. Urine culture on admission grew 10⁴ colonies per ml of *S. aureus* with the same sensitivity pattern. At this time the ampicillin was discontinued and oxacillin in a dose

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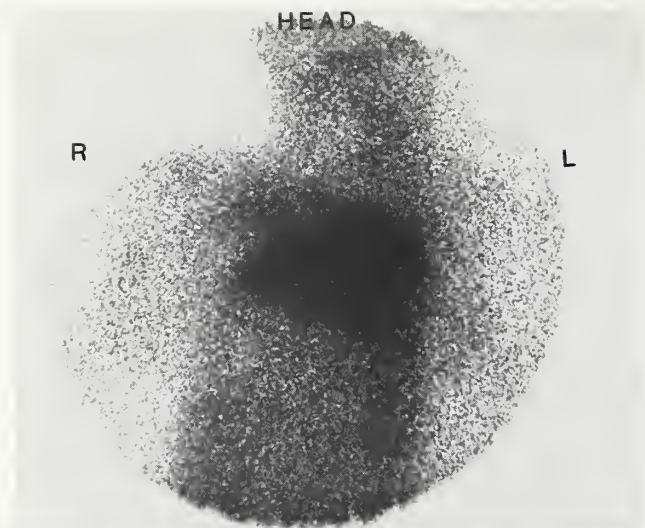


Figure 1—Gallium 67 citrate scan of the upper body, anterior view, showing increased uptake over right sternoclavicular area.

of 2 gm intravenously every four hours was begun. Tobramycin was discontinued a few days later.

Because of his persistent lethargy, a CT scan of the head was performed and was normal. Lumbar puncture on day four yielded cloudy fluid with 113,000 RBC and 144 WBC per cubic millimeter with 100 percent PMNs. The protein was 57 mg/dl and the glucose 37 mg/dl with simultaneous blood sugar of 110 mg/dl. CSF culture was negative. Ultrasound of the right upper quadrant was normal. M-mode and 2-D echocardiogram showed mitral valve prolapse but no vegetations.

A repeat aspiration of the chest wall mass again yielded bloody fluid, but this time the culture was positive for *S. aureus*. Blood cultures done at this time were negative. Attention was focused more on the mass and a gallium 67 citrate scan (Figure 1) was performed. This showed markedly increased uptake in the area of the swelling.

By day ten the fever was slowly declining and the mental status improving. The chest wall mass had become slightly fluctuant but incision and drainage did not yield frank pus. A CT scan of the chest (Figure 2) showed a soft tissue mass in the right pectoral region extending into the right anterior mediastinum with widening and decalcification of the right sternoclavicular joint.

On day 18, surgical resection of the medial end of the right clavicle, sternoclavicular joint, and first costal cartilage with drainage of an anterior medial sternal abscess communicating with the joint were performed. The postoperative course was uneventful. The patient received a total of 37 days of treatment with oxacillin.

COMMENT

The sternoclavicular joint includes a fibrocartilagenous meniscus interposed between the sternum and clavicle and lined with synovium which forms two separate cavities. The meniscus is attached inferiorly to the first rib at the sternal junction. The joint is surrounded by a fibrous capsule and is in close proximity to the trachea, large muscles of the neck,

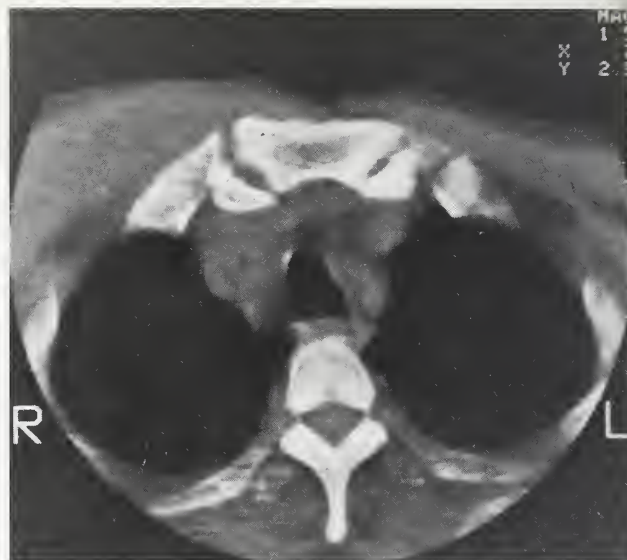


Figure 2—Computerized tomography of upper chest showing destruction of right sternoclavicular joint and anterior mediastinal abscess.

sternohyoid muscle, and anterior superior mediastinum.^{4,5} Infection spreading beyond the capsule, as in this case, can involve one of these important structures with potentially serious results.

Aside from gonorrhea, *S. aureus* and *Pseudomonas aeruginosa* are by far the most common etiologies of sternoclavicular joint pyarthrosis. Mycobacteria and fungi rarely have been reported.^{4,5} Infection must be differentiated from such rheumatologic conditions as rheumatoid arthritis, osteoarthritis, and Tietze's syndrome. In the appropriate setting, dislocation, hemarthrosis, aseptic necrosis, Paget's disease, and metastatic carcinoma must be considered.^{4,6}

Several predisposing conditions for sternoclavicular joint septic arthritis have been recognized. The most common one is intravenous drug abuse, presumably due to frequent bacteremias. Presentation generally is subacute with minimal systemic symptoms and signs and negative blood cultures. *S. aureus* and gram-negative rods, especially *P. aeruginosa*, are the most common pathogens.^{5,7,8} Rheumatoid arthritis is a well-recognized predisposing factor for septic arthritis and the sternoclavicular joint may be prone to infection.⁴ Sternoclavicular joint infection also is a rare complication of subclavian venous catheter insertion.⁹

Some patients have no obvious underlying condition and develop sternoclavicular joint pyarthrosis secondary to an inapparent bacteremia associated with musculoskeletal complaints alone. This is not uncommon in sternoclavicular joint pyarthrosis and can lead to prolonged delays¹⁰ in diagnosis (up to 3½ months in one series⁷). Arthritis is a well-recognized complication of bacterial endocarditis, as may have been the case in this patient. In one large retrospective series, 15 percent of the patients were noted to have arthritis, with this as the initial manifestation in 4 percent.¹¹ It is noteworthy that sternoclavicular joint was involved in 4 of 38 joints (11 percent).

While the sternoclavicular joint is relatively easy to examine, radiologic evaluation was difficult until recently. Plain films of the joint often are read as negative because of the confluence of structures in the area. A

high index of suspicion is needed to pursue the evaluation successfully.⁴ If an inflammatory or destructive bony lesion is suspected, technetium 99 bone and/or gallium 67 citrate scans can be helpful. Sternoclavicular joint tomography has been used, but computerized tomography of the region now is the preferred examination modality.⁶ In addition to being rapid and noninvasive, CT delineates bony and soft tissue lesions accurately and in anatomic detail.⁶ Our patient had clinically unsuspected mediastinal extension of infection which was shown on CT and allowed for definitive drainage at the time of joint resection.

Etiologic diagnosis is important for therapy. While blood cultures generally are negative, except in the setting of acute sepsis or endocarditis, they should be done. Diagnostic closed arthrocentesis may be successful, but if it is not and blood cultures are negative, open debridement with cultures is necessary.

Prolonged intravenous antibiotics are critical for cure. *S. aureus* requires four to six weeks of a semi-synthetic penicillin, e.g. nafcillin, oxacillin, a first-generation cephalosporin (cephalothin or cefazolin) or if the organism is sensitive, penicillin G. Patients who are allergic to penicillin can be treated with vancomycin. *P. aeruginosa* is best treated with a combination of an aminoglycoside (gentamicin or tobramycin) plus an antipseudomonal penicillin (ticarcillin, piperacillin, or mezlocillin) for four to six weeks. The presence of osteomyelitis or an underlying endocarditis may dictate a longer duration of therapy.⁴

Complications of sternoclavicular joint arthritis include extension into the mediastinum, as in our pa-

tient, and fistula formation. These complications and lack of response to prolonged antibiotic therapy require extensive surgery with proper drainage; at times, resection of the medial clavicular head is necessary. Chronic untreated infection may lead to squamous carcinoma. On occasion, a chronic fistula cannot be cured but can be suppressed by lifetime oral antibiotic use.

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*with apologies to Aesculapius

CASE REPORT: ANOMALOUS JUNCTION OF THE PANCREATICOBILIARY DUCTAL SYSTEM

RALPH S. GRECO, M.D., AND STANLEY Z. TROOSKIN, M.D., NEW BRUNSWICK*

An adult with anomalous junction of the pancreaticobiliary ductal system (AJPBDS) resulting in cystic dilatation of the common bile duct is described. She was managed by sphincteroplasty, cyst excision, and Roux-en-Y choledochojejunostomy. AJPBDS allows reflux of pancreatic secretions into the bile duct at high pressures.

Over 1,400 cases of choledochal cysts have been described in the literature; one-third of these have been found in adults. The anatomical relationship between the acquired adult choledochal cyst and pancreaticobiliary ductal pathology now is recognized more frequently because of the increased use of endoscopic retrograde cholangiopancreatography (ERCP). In the following case report, the association of anomalous junction of the pancreaticobiliary ductal system (AJPBDS), chronic pancreatitis, and cystic dilatation of the common bile duct is demonstrated.

CASE REPORT

A 20-year-old obese female was admitted to Middlesex General-University Hospital in November 1983 for epigastric and back pain. She had a history of episodic abdominal pain dating to early childhood. In 1977, she underwent exploratory laparotomy for an acute abdominal syndrome due to hemorrhagic pancreatitis. This was treated with cholecystostomy and sump drainage. After a complicated postoperative course, she recovered. An ERCP obtained prior to discharge revealed dilation of the common bile duct which was thought to be secondary to the recent episode of pancreatitis. In 1979, she was hospitalized for a second episode of pancreatitis. ERCP (Figure 1) demonstrated a dilated proximal common bile duct, a narrow distal common bile duct, a normal size pancreatic duct, and

an ovoid collection of contrast into which both ducts emptied.

At the time of admission to Middlesex General-University Hospital in November 1983, she was afebrile with stable vital signs. The abdominal examination was unremarkable except for epigastric tenderness. There were no masses palpated and her rectal examination was normal. Complete blood count, electrolytes, blood urea nitrogen, and serum hepatic and pancreatic enzymes were normal. The patient's pain and tenderness lessened after restricting oral intake and initiating intravenous hydration. An elective ERCP was unchanged from 1979. She was discharged on a low fat diet and readmitted in December 1984, at which time she underwent uneventful celiotomy and transduodenal sphincteroplasty. Postoperative t-tube cholangiography (Figure 2) revealed adequate emptying of contrast into the duodenum. However, the ovoid collection into which the biliary and pancreatic ducts had previously emptied no longer was present and there was unquestionable evidence of AJPBDS. The common bile duct joined the pancreatic duct at a 90° angle, 1.2 cm from the ampulla of Vater. In the month that followed, the patient's symptoms of epigastric pain recurred, and in February 1984, she was readmitted to

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Middlesex General-University Hospital. At that time, she underwent abdominal exploration, excision of the dilated common bile duct with re-establishment of biliary enteric continuity with a Roux-en-Y hepaticojejunostomy. Her postoperative course was uneventful. The patient presently is four months' postcyst excision and is asymptomatic with normal liver function tests and normal serum amylase.

DISCUSSION

In 1723, Vater described the anatomy of choledochal cysts.¹ Babbitt et al. described the anomalous junction of the common bile and pancreatic ducts and the association of this entity with cystic dilatation of the common bile duct in 1973.² Babbitt and his associates postulated that AJPBDS allowed reflux of pancreatic secretions into the bile duct and exposed the common bile duct to the higher pressures that normally occur in the pancreatic ductal system. Free flow of pancreatic secretions into the distal bile duct was thought to produce bouts of cholangitis and/or pancreatitis. With continuous exposure to pancreatic enzymes and pancreatic ductal pressure, the common bile duct eventually undergoes distal mucosal ulceration and resultant fibrosis with proximal bile duct cystic dilatation. Ono et al.³ described AJPBDS in 15 of 22 adult patients with choledochal cysts. All but 1 of these patients were described as type I choledochal cysts according to the modified Alonso-Lej classification. Half the patients were diagnosed by preoperative ERCP and the other half by intraoperative cholangiography. The radiologic criteria for AJPBDS described by Ono et al. is a 90° angle at the junction of the pancreatic and biliary ductal systems and a length of common channel for the pancreatic and common bile ducts residing outside the duodenum wall greater than 0.6 cm in length.

This patient's anatomic abnormality was obscured by ampullary stenosis related in all likelihood to recurrent pancreatitis. The ovoid collection of contrast seen on the initial ERCP study (Figure 1) represented the segment of the common bile duct between the ampulla and the junction of the ductal systems. Sphincteroplasty, in addition to theoretically improving the drainage from the main pancreatic duct, uncovered the classic radiologic picture of AJPBDS. Whether the sphincteroplasty will have a therapeutic effect of obviating future episodes of pancreatitis remains to be seen.

The traditional treatment of choledochal cyst, to a great degree derived from the experience in children, has been internal drainage. Recently, excision of the dilated common bile duct with Roux-en-Y hepaticojejunostomy has been advocated. Excision is based on three important sequelae of choledochal cysts.

The first of these is the high incidence of anastomotic stricture thought to be caused by the abnormal, ulcerated mucosa of the cyst wall, compounded by persistent pancreatic enzyme reflux. In patients with AJPBDS and recurrent pancreatitis, excision removes the common channel of the pancreatic and bile ducts. Perhaps of greater importance is the remarkable incidence of bile duct carcinoma in patients with choledochal cysts. Flanigan has shown that 2.5 percent of patients with choledochal cysts develop bile duct carcinomas.⁴ This is 20 times that seen in the general



Figure 1—Five years prior to admission, ERCP demonstrated (1) a dilated proximal common bile duct, (2) a narrow distal common bile duct, (3) a normal size pancreatic duct, and (4) an ovoid collection of contrast into which both ducts emptied.



Figure 2—A postoperative t-tube cholangiography done in December 1984 after a sphincteroplasty demonstrated AJPBDS. The (1) common bile duct joined the (2) pancreatic duct at a 90° angle 1.2 cm from the (3) ampulla Vater. The ovoid collection at which the biliary and pancreatic ducts previously emptied no longer is present.

population. The average age of diagnosis was 34 years which is younger than usual for bile duct cancer. Fifty percent of the 24 patients sought treatment for carcinoma an average of 4 years after internal drainage. Fifty-seven percent of the carcinomas arose in the cyst wall and would have been cured by preventive excision.

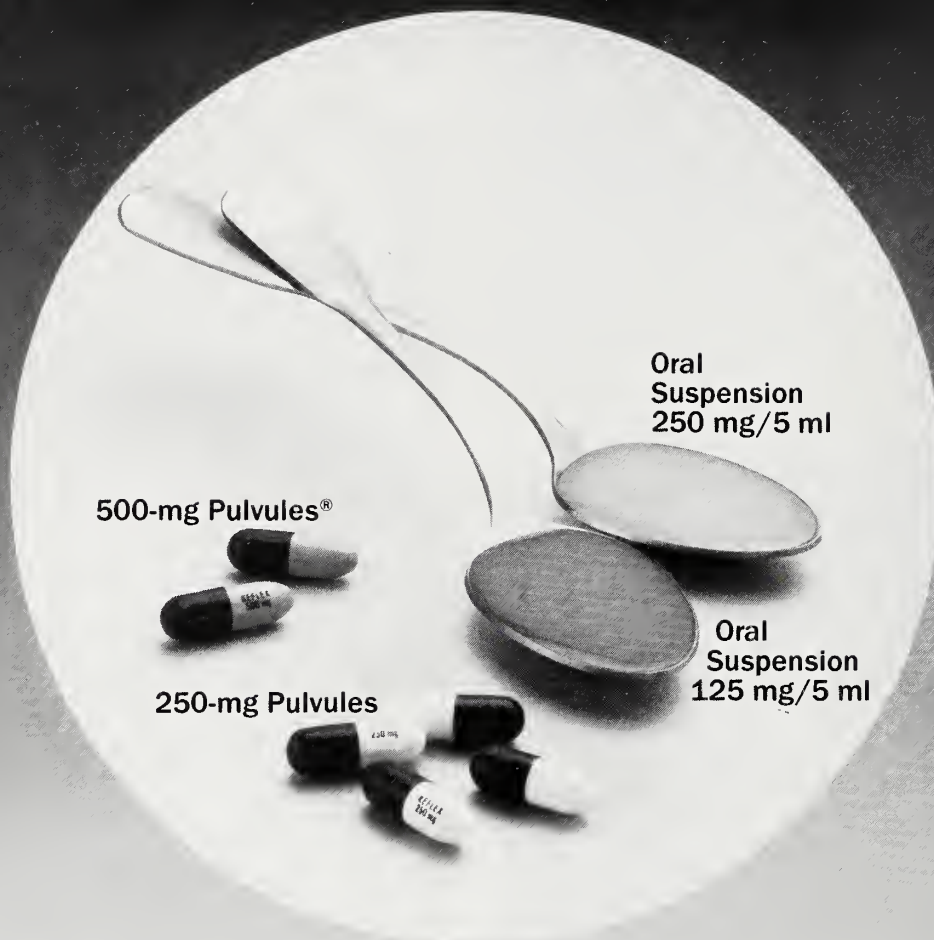
Endoscopic retrograde cholangiopancreatography has revolutionized pancreatic and biliary duct surgery. Preoperative evaluation of the anatomy of the region has resulted in the accurate diagnosis of heretofore obscure conditions and allows safe, effective, and well-planned operations. The association between AJPBDS, recurrent pancreatitis, and choledochal cysts now is well established. This diagnosis should be considered

seriously in patients with recurrent pancreatitis. Effective treatment requires common bile duct excision to avoid recurrent pancreatitis, anastomotic stricture, and the possible development of bile duct carcinoma.

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CASE REPORT: BULLOUS EMPHYSEMA AND PNEUMOTHORAX

FEDERICO A. PEGUERO, M.D., AND ALAN NETZMAN, D.O., CAMDEN*

Bullous emphysema with giant bullae occupying 25 percent or more of the lung can be corrected surgically. The lung tissue may be compressed. Resection of the bullae is therapeutic.

The development of spontaneous pneumothorax in patients with bullous emphysema may constitute an indication for surgical treatment if the pneumothorax is recurrent, persistent, or life endangering. When simple closed drainage does not solve the problem, a more vigorous approach must be pursued.¹³ The only surgical procedure for treatment of bullous emphysema which has withstood the test of time is simple bullae excision or plication.^{3, 14}

The following is a report of a patient treated surgically with moderately severe generalized pulmonary emphysema, a giant bulla, multiple apical blebs or bullae, and pneumothorax.

CASE REPORT

A 56-year-old black male was admitted to Metropolitan Hospital, Philadelphia, for chest discomfort, weakness, and shortness of breath. He gave a long-standing history of hypertension, emphysema with exertional dyspnea coronary artery disease, and emphysematous blebs of the lung. The patient related a 50-pack/year smoking history, chronic alcohol abuse, and a five-year period of heroin abuse (1955 to 1960), subsequently treated with methadone (1960 to 1964). His medications included Theo-Dur®, Minozidil®, Lasix®, and Corgard®. On physical examination, the patient was a thin man with a respiratory rate of 24/min. Breath sounds were diminished on the

left pulmonary field, particularly the left upper lobes. There was no clinical evidence of congestive heart failure.

A chest roentgenogram initially was interpreted as massive left pneumothorax with abnormal pulmonary markings. Subsequent x-ray examinations revealed a huge bullous formation on the left, partial left pneumothorax, mediastinal shift to the right, and compression of lung tissue. The film also suggested the presence of fluid in the dependent portion of the giant bulla. Determinations of arterial blood gas levels, with the patient breathing room air, showed hypoxemia and mixed metabolic and respiratory alkalosis. Pulmonary function studies revealed an FVC of 75 percent, FEV₁ of 63 percent, and FEV₁/FVC of 71 percent predicted, which is compatible with a combined mild obstructive and restrictive defect. Ventilation study of the lungs revealed no evidence of left lung ventilation. Gas exchange was performed by the right lung as shown in the preoperative performed scan (Figure 1).

On the tenth postadmission day we performed a closed thoracostomy. A 32F chest tube was inserted in the left fifth intercostal space at the midaxillary line.

*Dr. Peguero is Associate Surgeon, Division of Cardiothoracic Surgery, Cooper Hospital and Medical Center, Camden, and Dr. Netzman is Chief Resident, Department of Surgery, Metropolitan Hospital, Philadelphia. Correspondence may be addressed to Dr. Peguero, 1929 East Marlton Pike, Cherry Hill, NJ 08003.



Figure 1—Preoperative performed scan.

This procedure was delayed because of initial fears of rupturing the giant bullae and creation of massive air leak. Repeat chest films showed initial resolution of left pneumothorax and mediastinal shift, but these conditions recurred within 48 hours of chest tube insertion despite constant water seal suction.

We recognized that the only possibility of resolving the pneumothorax, mediastinal shift, and improving left lung function was to attempt removal of the giant bulla and to plicate any existing blebs.

Thoracotomy revealed a giant bulla which occupied the upper lobe and compressed all lobes inferiorly. The bulla, which was excised along its border with normal collapsed lung tissue, measured 20 x 19 x 0.3 cm (Figure 2). The compressed lung tissue was re-expanded almost immediately and occupied the upper hemithorax. The base of the bulla was plicated with stapler TA90. Multiple blebs on the apical surfaces of upper lobes were excised and plicated. Two 36F chest tubes were inserted and the old chest tube was removed. The parietal pleura was scored (poudrage) with a sponge and tetracycline solution (0.05% in normal saline solution) irrigated the left hemithorax to promote pleural adhesions.

The postoperative course was uncomplicated. A small air leak persisted but this was resolved by postoperative day 21. Postoperative arterial blood gases showed little change and were demonstrative of generalized lung disease. Postoperative chest films revealed complete lung re-expansion in the left hemithorax with no pneumothorax or mediastinal shift. Clinical improvement was best exhibited on the postoperative ventilation and perfusion scan, now showing that gas exchange was being performed by both lungs.

DISCUSSION

The prevailing definition of a bulla, as proposed by the CIBA symposium report of 1959, is an air-containing space greater than 1 cm in diameter in the distended state within the lung.¹⁵ The word "bleb" usually denotes a collection of air within the layers of visceral pleura; this lesion often is associated with the development of spontaneous pneumothorax.¹⁰

Bullae of the lung can be divided into four main groups.⁵ Group 1 consists of a single large bulla present in a normal healthy lung. This may be a congenital cyst or an apical bleb. It may be related to Marfan's syndrome, sequestration, anomalous pulmonary ar-



Figure 2—Giant bulla that was excised.

teries, or tuberculosis. Group 2 is composed of multiple bullae with well-preserved pulmonary function. This may be the result of congenital fibrocystic dysplasia, early chronic obstructive pulmonary disease, or interstitial fibrosis. Surgery in these first two groups, if indicated, frequently is successful in relieving symptoms. Group 3 consists of bullae and generalized emphysema. Ventilatory impairment often is severe. This group of patients offers the greatest challenge to the thoracic surgeon and presents the worst surgical prognosis. In Group 4 are cysts or bullae related to other lesions such as scleroderma, Hamman-Rich syndrome, eosinophilic granuloma, or tuberous sclerosis. In these patients, the amount of functional impairment usually is related to the underlying disease and not to the bullae.¹¹

Our patient falls into Group 3. He was a heavy smoker, an almost universal habit associated with this disease.^{8,14} Preoperative arterial blood gases, spirometry, and ventilation perfusion studies classified the patient as having moderately severe, generalized, or panlobar emphysema.

Giant emphysematous bullae usually result from factors which initiate lung traction in emphysema, such as fibrosis or atelectasis, and from loss of elasticity, destruction of pulmonary tissue, and bronchial obstruction with trapping of air.³ The largest bullae, even when the lung is diffusely involved with emphysema, tend to occur in the upper parts of the upper lobes.

Giant bullae exert an untoward effect on the remainder of pulmonary substance. They occupy space and compress the remaining lung. If the residual tissue is relatively normal, this compression is harmful. Large bullae rarely are the seat of clinically apparent infection and often do not become filled with fluid. Even infection tends to remain confined by the wall without the destruction characteristic of abscess and without a tendency to involve the surrounding parenchyma further. Rarely, hemorrhage may occur from the wall of the bulla which, when filled, may be mistaken for a tumor on the x-ray. Fitzgerald et al. in a presentation of 84 patients with bullous emphysema encountered only 1 patient in whom bleeding was traced bronchoscopically to the bullous area.¹⁴

In pulmonary emphysema, there is ever-present danger of spontaneous pneumothorax. Delarue et al.¹³ found 8 patients with spontaneous pneumothorax out of a total of 55 patients with generalized emphysema

and bullous disease. All 8 patients required surgical intervention when closed thoracostomy failed to resolve the problem. Two of the patients died post-operatively, indicating a much higher operative mortality when pneumothorax complicates bullous disease as compared to a 2 percent mortality without pneumothorax.^{5,7,8,14} Fitzgerald et al. report of operations on 18 patients (of 84 with bullous disease) primarily because of recurrent pneumothorax.¹⁴ There were no recurrences following excisional surgery.

INDICATIONS FOR SURGERY

The common indication, often the only one, is progressive dyspnea on exertion.^{3,14} Pneumothorax, especially when persistent and symptomatic, is another. Infection and hemoptysis are encountered rarely.

SURGICAL PROCEDURES

A wide spectrum of surgical procedures has been employed in the therapy of diffuse obstructive emphysema with or without giant bullae. These include plastic procedures upon ribs and sternum, relocation of the diaphragm, intubation or open drainage of the larger bullae¹⁶ (Monaldi drainage), and lobectomy. None of these operations has been of sufficient permanent value to be currently employed.^{1,3,14,7,10} As stated previously, only local excision of bullae with preservation of remaining lung tissue is considered appropriate surgical therapy for giant bullous disease.

PREOPERATIVE EVALUATION

Possible candidates for surgical intervention are patients with severe chronic obstructive pulmonary disease (COPD) and obvious x-ray evidence of bullous emphysema. The standard chest x-ray allows an assessment of the degree of compression of neighboring lung.⁷ If obvious compression of surrounding lung tissue is present, improvement generally can be expected following bullectomy. If the accompanying lung reveals marked degenerative changes with the presence of smaller cystic areas and no obvious compression, a satisfactory postoperative result is unlikely.

Determination of ventilatory function with spirometry is mandatory for evaluation of operative risk. Normal subjects are capable of exhaling 80 percent of their normal vital capacity in the first second (FEV₁). As ventilatory capacity decreases, operative risk increases. If FEV₁/FVC is below 50 percent of predicted, there is significant risk in thoracotomy.⁷ If, however, excision of the bullae allows the compressed lung to expand, significant ventilatory improvement may result, justifying surgical risk. Ventilation studies assess ventilation in all regions of the lung and can estimate the amount of bullous emphysema present. Perfusion scanning gives further estimates of the degree of underlying lung disease and is safer than pulmonary angiography. Some authors prefer angiography because it is considered more accurate in assessment of blood flow.¹⁴

If arterial blood gas studies reveal significant hypercapnea and hypoxia, an unfavorable surgical outcome generally can be expected. Resection of bullae less than 25 percent of one hemithorax has resulted in very few subjective or objective postoperative improvements.^{4,12,14} In spite of the battery of tests applied to the problem, there often remains much doubt as to which patient can benefit from surgery.^{2,4,6} The surgeon may expect only 50 percent of patients with severe bullous emphysema and underlying generalized emphysema to significantly improve symptomatically.^{1,5,11,13,14} The patient in this report claims to have benefited from the surgical procedure with mild reduction in his dyspnea, although his arterial blood gases virtually have remained unchanged.

SUMMARY

Bullous emphysema should be treated surgically if it occupies more than 20 percent of the lung volume. The greatest challenge to the thoracic surgeon is bullous emphysema associated with generalized emphysema. It is easy to confuse a giant bulla with pneumothorax. If a mistake is made and a chest tube is inserted into a bulla and massive air leak occurs, surgical correction is essential. Multiple procedures have been described to correct this entity, but the best one that has prevailed the test of time is thoracotomy and bullectomy.

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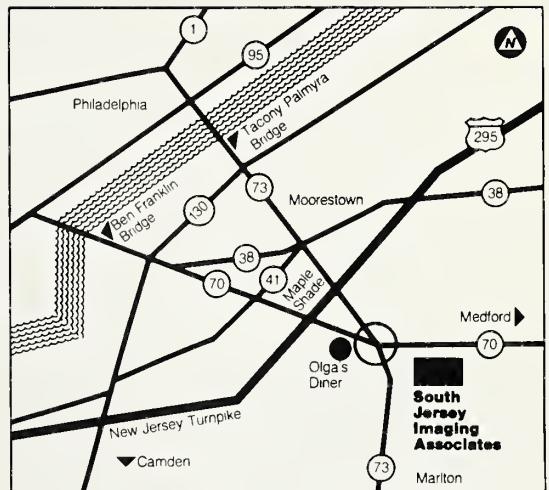
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DOCTORS' NOTEBOOK

Trustees' Minutes; UMDNJ Notes; AMNJ Report; Physicians Seeking Location in New Jersey

Trustees' Minutes July 21, 1985

A regular meeting of the Board of Trustees was held on July 21, 1985, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . .

Task Force on Senior Citizens . . . Commended Dr. Fioretti for his presentation at the Senior Citizens Health Care Forum, sponsored by Congressman Rinaldo.

Report of Executive Director . . .

(1) MSNJ 1985 Paid Membership . . . Noted that paid membership as of June 30, 1985, was 7,287.

(2) MSNJ Financial Statements . . . Approved MSNJ's financial statements for the periods ending April 30, 1985, and May 31, 1985.

(3) Legislation Update . . .

(a) S-2869-Certificate of Need for Regionalized Services . . . Noted that this bill is out of committee; a

time has not been set for a vote in the Senate.

(b) Professional Liability Package . . .

Noted that testimony on medical malpractice bills reflected the technical approach to tort reform.

(4) Medical Inter-Insurance Exchange of New Jersey . . .

(a) Misleading Agency Publication . . .

Noted that in an upcoming company newsletter Peter Sweetland, President of the Exchange, will respond to the misleading information on the financial status of the Exchange.

(b) Reporting of Potential Claims . . .

Noted that for reporting purposes, the Exchange uses the following divisions: 1) Level 1: report from a physician not likely to become a suit; 2) Level 2: report from a physician that has the likelihood of becoming a suit; 3) Level 3: notification of a claim from either the patient or his or her attorney; and 4) Level 4: a filed suit.

(5) AMA Lawsuit: Medicare Provisions in Deficit Reduction Act . . .

Noted that the lawsuit challenging the constitutionality of certain Medicare provisions in the Deficit Reduction Act has been dismissed by the federal district court.

(6) Medicare Waiver . . . Noted that NJ federal district court Judge Ann Thompson issued a permanent restraining order against the Health Care Financing Administration on their position that the outpatient waiver was not part of the initial waiver granted under the DRG program.

(7) Litigation by Medical Society in Oregon . . .

Noted that a lawsuit has been filed under the federal Freedom of Information Act by a county medical society in Oregon to have released the list of Medicare recipients; the society wants to inform the Medicare beneficiaries what the reimbursement system is doing.

(8) DRG Appeals Process . . .

Noted that the Department of Health was notified of the Committee on Peer Review position stating that it is inappropriate for a carrier or intermediary to request a retroactive review of an admission that initially had been certified as medically necessary by a peer reviewer.

(9) Health Care Administration Board/Statewide Health Coordinating Council Seminar . . .

Noted that at a future meeting of HCAB/SHCC, Mr. Maressa will ad-

dress the issue on how the state's policies on capital reimbursement impact the future of physicians.

New Jersey Hospital Association . . .

Was informed that the Association is bringing a suit against the State Board of Nursing because of their attempts to regulate hospital technicians.

AMA Hospital Medical Staff Section Fifth Assembly Meeting . . .

Voted to commend Dr. A. Ralph Kristeller for his outstanding leadership as chairman of the AMA-Hospital Medical Staff Section-MSNJ.

AMA Annual Meeting . . .

Received a letter of appreciation from Dr. Palma E. Formica acknowledging MSNJ's encouragement and support of her AMA Board of Trustees campaign.

Committee on Medical Aspects of Sports . . .

Approved the following recommendation:

That the Board of Trustees support the use of protective headgear for horseback riders in order to prevent or reduce the severity of injuries.

Old Business . . .

(1) Preadmission Review/Certification—Resolution #14 (1985) . . .

Noted that if Mr. Maressa receives evidence showing that the criteria used and decisions reached are medically inappropriate relative to the PRO preadmission review/certification process, he would present such information.

(2) Expert Medical Opinion—Resolution #22 (1985) . . .

Approved the following recommendation:

That Resolution #22 be referred to the State Board of Medical Examiners, with the request that they consider it for rule making purposes.

(3) PRO Screening Criteria . . .

Received as information, a copy of the revised PRO screening criteria as approved by the PRO of New Jersey Board of Trustees and the Health Care Financing Administration.

(4) Guidelines for a Podiatry Department or Section . . .

Accepted proposed revisions and approved the proposed operating procedures of the "Guidelines for a Podiatry Department or Section."

(5) Guidelines for Supportive Care

Plans . . . Referred to the Committee on Biomedical Ethics for consideration a communication suggesting amendments to the "Guidelines for Supportive Care Plans."

(6) Same Day Surgery Regulations . . . Will forward regulations to the Department of Health indicating that a decision as to whether a surgical procedure is major or minor or inpatient or outpatient is one that should be reached by the attending physician, the anesthesiologist, and the patient.

New Business . . .

Policy Statement of SBME on Withholding or Withdrawing Medical Treatment . . . Noted that a communication will be sent to the SBME urging reconsideration of its adopted policy on "do not resuscitate" orders.

UMDNJ Notes

**Stanley S. Bergen, Jr., M.D.
President**

It gives me great pleasure to welcome back Dr. Bernard J. Goldstein to UMDNJ and to New Jersey. Dr. Goldstein has resumed his position as chairman of the department of

environmental and community medicine at UMDNJ-Rutgers Medical School, Piscataway. Dr. Goldstein's return means that the state's health sciences university will have the services of a fine scientist and administrator—not only in his role as department chairman, but also as director of the state's first Environmental Health Sciences Institute.

A joint venture between UMDNJ and Rutgers, the State University, the Institute will be constructed on the Busch Campus, which the institutions share in Piscataway.

With Dr. Goldstein at the helm, the Environmental Health Science Institute will conduct research into the effects of toxic substances on human health, while also better informing citizens on occupational and environmental diseases. It will bring together medical doctors, toxicologists, and other scientists who will concentrate on developing methods to control hazards that threaten our environment.

We welcomed Herbert G. Stolzer, a member of the Executive Committee and Board of Directors of Johnson & Johnson, to our Board of Trustees. Mr. Stolzer, a resident of East Brunswick, was nominated by Gov-

ernor Thomas H. Kean to a three-year term, and the State Senate approved the nomination. Since joining Johnson & Johnson in 1951, he has held many positions in manufacturing, engineering, and management for Johnson & Johnson Products, Inc. He was named its president in 1972 and chairman four years later.

The effect of television violence on school children has long been a point of concern for parents, teachers, and health professionals alike. When one considers that, on average, children will accumulate approximately 22,000 hours of television viewing by the time they graduate from high school compared to 11,000 hours in the classroom, the worry is justified indeed. According to a special UMDNJ study team, creation of a special Presidential Commission to look into television violence is just one of many actions that must be taken.

The survey was conducted by six members of the Department of Preventive Medicine and Community Health at UMDNJ-New Jersey Medical School, Newark, who reviewed the findings of physicians, psychologists, and others who analyzed television viewing over the past two dec-

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Programs may be taped for alternate viewing times.

ades. They cited 35 separate studies in the report, which includes a bibliography of more than 160 publications from this country and overseas.

Acknowledging that it is "very difficult to prove conclusively the adverse effects of violent television programming," the group's Television Task Force Report contends that "viewing of gratuitous violence may be harmful to many people, and is surely harmful to some segments of the population."

The team—consisting of UMDNJ faculty members Mark A. Quinones, Ph.D., Marina R. Passannante, Ph.D., Kathleen M. Doyle, Alex Wyssession, Donald B. Louria, M.D., and Jules Titelbaum, M.D.—observed that children ages 8 to 11 are most sensitive. They watch an increasing amount of violence-oriented programming, but are still too young to distinguish between fantasy and the real world.

"We must realize that any intervention aimed at the improvement of children's television is not enough because many children spend many hours viewing adult programming," the report concludes. "Therefore, the violent content of programs for both children and adults must be curbed."

In addition to the formation of the Presidential Commission, the group urged the following: information for adults and children—provided through the schools—regarding potential harm associated with TV violence; legislation establishing a National Endowment for Children's Television; increased state support for public television; and increased research into the effects of TV violence on human behavior.

AMNJ Report

Dennis R. Filippone, M.D.
President

The Academy of Medicine's Annual Awards Dinner held on May 29, 1985, at the Chanticleer in Short Hills was a major success. Approximately 400 guests were in attendance and unfortunately a number of people had to be turned away due to seating limitation. Our 1986 event will be held at the Chanticleer and the date of Wednesday, May 28, 1986, has been reserved. The Awards Committee, under the chairmanship of immediate past-president, Bob Rigolosi, presently is soliciting

nominations for 1986.

The Academy's staff is actively preparing the Annual Calendar for 1985-1986 which is our major CME publication. The Calendar will include 600 CME activities for the forthcoming academic year and represents about half of the total number of programs we will sponsor and jointly sponsor for the year.

The Calendar includes many other items including a list of our active speakers, topics, a list of our affiliated societies and their presidents, and an application for our clinical and public education Speakers Bureaus. We again extend our thanks to Hoffmann-LaRoche for their generosity in printing the document.

The First Annual Academy-sponsored lecture for medical students was held on Wednesday, June 26, 1985, at the Middlesex General-University Hospital, New Brunswick. Our guest speaker was Dr. Ronald Carson, Director, Institute for the Medical Humanities, University of Texas Medical School at Galveston who addressed "Who Will Look After the Medical Commons?" The Academy's Director of Medical Education, Dr. Alfred Alessi, welcomed the students and guests and informed those present that we expect this to be an annual event. Our thanks to Dean Richard Reynolds for his help in organizing the day.

The Long-Range Planning Committee met and their primary topic of conversation was the Academy's 75th anniversary which will be celebrated in 1986. A number of potential activities were discussed and included an appropriate article to be submitted to *The Journal*, preparation of a special logo, and the planning of joint meetings with other prestigious organizations. Further discussion will be held at the Committee's next meeting in September. Dr. Hal Bruck is the committee chairman.

At the Academy's January 1985 Board of Trustees Retreat, it was suggested that we offer a free one-year membership to all 1985 UMDNJ graduates. The idea was to involve the young residents early in their careers and hope to keep them interested. We are delighted to report that as of this writing over 70 graduates have taken us up on our offer and have been made Associate Fellows of AMNJ.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

CARDIOLOGY—Bruce Klein, M.D., 438A Willow Turn, Mt. Laurel, NJ 08054. SUNY-Downstate 1977. Also, pediatric. Board certified (PD). Group, HMO, hospital. Available.

M.A. Mottaghian, M.D., 118 Vernal St., Everett, MA 02149. Isfahan Medical (Iran) 1965. Board eligible. Also, internal medicine. Full- or part-time practice. Available.

DERMATOLOGY—Rami Ephraim Geffner, M.D., 1139 N. Church St., Apt. A-3, Greensboro, NC 27401. UMDNJ 1979. Group, solo, partnership. Available.

FAMILY MEDICINE—Mark T. Bright, M.D., 1718 Afton Ave., Charleston, SC 29407. Georgetown 1978. Board certified. Group or partnership. Available.

Steven Luke, M.D., 3246 Abell Ave., Baltimore, MD 21218. SUNY 1982. Board eligible. Group or HMO. Available.

Daniel Nuchovich, M.D., 1006 Bay Dr., #702, Miami Beach, FL 33141. University of Uruguay 1980. Health center, hospital, underserved area. Available.

INTERNAL MEDICINE—Diane Bruzzi, M.D., 638 Colonial Arms Rd., Union, NJ 07083. St. George University (West Indies) 1982. Board eligible. Group, partnership, clinic, nursing home. Available.

Harold B. Ehrlich, M.D., 41 Elmwood Ave., Union, NJ 07083. St. George University (West Indies) 1982. Board eligible. Group, partnership, clinic, nursing home. Available.

Frederic M. Heltzer, M.D., 3rd Ave., 160B Borden Apts., Long Branch, NJ 07740. UMDNJ 1982. Group, partnership, clinic, industry. Available.

Marvin H. Lerner, M.D., 233 E. 32 St., #4J, New York, NY 10016. Universidad Autonoma (Mexico) 1982. Board eligible. Group, partnership, solo. Available.

M.A. Mottaghian, M.D., 118 Vernal St., Everett, MA 02149. Isfahan Medical (Iran) 1965. Board eligible. Also, cardiology. Full- or part-time practice. Available.

Z. Shamma-Othman, M.D., 533 Evergreen Ct., Bensalem, PA 19020. Baghdad University (Iraq) 1979. Group or partnership. Available.

Robert E. Sunenblick, M.D., 3355 Queen Mary Rd., #427, Montreal, Que-

bec, Canada H3V 1A5. Hahnemann
1974. Solo, group, partnership, HMO.
Available.

NEUROLOGY—Jaime Lim, M.D., Sum-
mit Park East, Apt. F-1, 8201 Henry
Ave., Philadelphia, PA 19128. Univer-
sity of the East 1980. Group or solo.
Available.

Fredric M. Radoff, M.D., 7832 91 St., N.,
Seminole, FL 33543. UMDNJ 1976.
Board certified. Available.

NUCLEAR MEDICINE—William Ganz,
M.D., 7476 Ahern Ct., University City,
MO 63130. Also, radiology. Hospital or
group. Available.

PATHOLOGY—Adam G. Lang, M.D.,
1436 Armacost Ave., Apt. 9, Los An-
geles, CA 90025. Illinois 1980. Group
or partnership. Available.

Janet Schneller, M.D., 174 E. 206 St.,
Bronx, NY 10458. NY Medical College
1979. Board eligible. Hospital based.
Available.

PEDIATRICS—Patrick A. Caruso, M.D.,
157 Goodwin St., Bristol, CT 06010.
Case Western Reserve 1983. Board
eligible. Group or HMO. Available.

Meera Gupta, M.D., 57 Lawrence Dr.,
Berkeley Heights, NJ 07922. India
1976. Board eligible. Group, partner-
ship, hospital. Available.

Bruce Klein, M.D., 438A Willow Turn,
Mt. Laurel, NJ 08054. SUNY-Downstate
1977. Also, cardiology. Board certified.
Group, HMO, hospital. Available.

Edgar Lyubling, M.D., 1401 Ocean Ave.,
Apt. 4H, Brooklyn, NY 11230. Moscow
(USSR) 1967. Group or partnership.
Available.

Boroumand Masood, M.D., 85-26 Van
Wyck Expwy., Apt. 412, Briarwood, NY
11435. Tehran (Iran) 1968. Board
certified. Group, partnership, solo, hos-
pital. Available.

Pronoti Nigam, M.D., 24 Hart Blvd.,
Flemington, NJ 08822. Kanpur (India).
Board eligible. Group or partnership.
Available.

Vito A. Petrozzino, M.D., 1201 West
McGaffey, #39, Rosewell, NM 88201.
Guadalajara (Mexico) 1976. Board
eligible. Group or partnership. Avail-
able.

RADIOLOGY—William Ganz, M.D., 7476
Ahern Ct., University City, MO 63130.
Also, nuclear medicine. Hospital or
group. Available.

SURGERY—Anthony J. Menichino, M.D.,
82 Niagara Falls Blvd., Buffalo, NY
14214. Guadalajara (Mexico) 1973.
Board eligible. Group, partnership,
solo. Available.

Dan S. Reiner, M.D., 7028 Waterman
Ave., St. Louis, MO 63130. St. Louis
1980. Board eligible. Group or partner-
ship. Available.

UROLOGY—Barry R. Shepard, M.D., 30
So. Central Ave., Valley Stream, NY
11580. SUNY 1979. Board eligible.
Available.

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AVAILABLE: Bottles of 100, 500.

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Riboflavin (B-2)		2 mg.
Pyridoxine HCL (B-6)		10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

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associated with impaired peri-
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SIXTH ANNUAL MEDICOLEGAL SEMINAR

Wednesday, October 23, 1985

8:30 A.M.-12:30 P.M.

Medical Society of New Jersey Executive Offices
Two Princess Road
Lawrenceville, NJ 08648

presented by

Medical Society of New Jersey
Department of Professional
Liability Control

Medical Inter-Insurance
Exchange of New Jersey
Department of Risk Prevention

8:30- 9:00

Registration

9:00-11:15

General Session

Opening Remarks

*James E. George, M.D., J.D.
Director, Department of
Professional Liability Control*

Greetings

*Ralph J. Fioretti, M.D., President
Medical Society of New Jersey
and
Peter Sweetland, President
Medical Inter-Insurance Exchange
of New Jersey*

**AMA Response to a
National Crisis**

*Raymond Scalettar, M.D.
Newly elected member AMA Board
of Trustees, Vice-Chairman, Board
of Directors of the Washington, DC
physician-owned insurance carrier,
Chairman AMA's Committee on
Professional Liability*

**A Report on NJ Department of
Insurance Task Force on
Professional Liability**

*Commissioner Hazel Gluck
Commissioner of the New Jersey
Department of Insurance*

**Tort Reform—
A Legislative Update**

*Robert S. Maurer, D.O., Chairman
Legislative Committee, Medical
Inter-Insurance Exchange of New Jersey*

11:15-12:00

Question and Answer Period

12:00-12:30

Lunch

3 CME CATEGORY 1 CREDITS APPROVED

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NO REFUNDS AFTER OCTOBER 21, 1985

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A CONFIRMATION WILL BE SENT TO YOU ALONG WITH DIRECTIONS TO MSNJ

LETTERS TO THE EDITOR

MSNJ Advertisement; Pilonidal Cyst; Threshold Attainers

MSNJ Advertisement

May 24, 1985

Dear Doctor Krosnick:

I have written the following regarding MSNJ's ad entitled "A Personal Message to My Medicare Patients." The essay clearly is opposed to the sentiments expressed in this ad, but I feel it expresses a point of view that MSNJ had tended to overlook or disregard and deserves publication for this reason.

MSNJ placed an ad in many newspapers in this state which implied that the efforts of the peer review organizations were designed to cause serious harm to patients and the patient care system.

As written, the advertisement seemed designed to arouse hostility among Medicare beneficiaries. Indeed, its lack of factual material and its tone bordered on rabble-rousing.

It is unfortunate the MSNJ should choose such a role for itself from several aspects. The most important of these is the necessity for the Society to place itself in the position of dispassionate arbiter of all medical matters to ensure the orderly development of trends, practices, and technologies that bear on the overall practice of medicine. Additionally, the state Medical Society has an ob-

ligation to support the reasonable efforts of those of its members who are legitimately pursuing a course of action that is designed to result in improvements in the delivery of patient care. Finally, the state Medical Society has an obligation to its members and to all the people of this state to present material and viewpoints regarding medical practice that are factually sound.

The peer review organizations of this state have been founded by practicing physicians who felt that physicians should review the work of physicians, rather than insurance clerks. The experience gained with review by clerks in the early days of the Medicare program was very helpful in arriving at this conclusion. Many members of MSNJ labored long and hard to make these organizations work, despite the opposition of the entrenched federal and state bureaucracies, and many very harmful budget cuts imposed by the federal government seeking elimination of physicians from this work. As well, the irritation of many physicians at having their decisions open to question did not help the development of such a program.

These peer review organizations have from their inception maintained the belief that the cheapest possible care was based on patient care that was medically necessary and of good quality. This belief still is the operative motivation in the present form of peer review.

There is no question that there are some facilities and practitioners who provide exceptional patient care. It equally is true that there are facilities and practitioners where patient care is far below a minimally acceptable level.

In analyzing its statistics, the peer review organization must spell out, under federal regulation, what it can reasonably expect to accomplish. Knowing the degree of poor performance, it can indicate roughly how many unnecessary admissions and unnecessary days it can eliminate from hospital stays.

Far from being inflexible, the peer review organization has provided a very effective appeal mechanism that is open to patients, physicians, and hospitals. Additionally, the physician reviewers make reasonable efforts to contact attending physicians prior to rendering decisions on any case.

Prior to placing any more such advertisements, MSNJ would do well to consider its own role. While rabble-rousing may win many temporary supporters, in the long run, such efforts burst like a balloon that has risen too high when the cold hard light of fact is entered into the situation.

(signed) William A. Dwyer, Jr., M.D.

June 5, 1985

Dear Doctor Krosnick:

Thank you for sharing Doctor Dwyer's offering with me.

As far as I am concerned, the ad we released is objective and truthful and rather temperate.

I am puzzled by Doctor Dwyer's comments since he provides no documentation. Further, the PRO has not provided a responsive and flexible appeal mechanism. Both you and I receive calls and letters weekly regarding its nonresponsiveness and have experienced it first-hand.

I stand on the content of the ad. The ad reads as follows:

"In an effort to control federal expenses related to Medicare, the U.S. Government has contracted with Professional Review Organizations in each state.

"The goals of these organizations are to reduce the number of admissions to hospitals of Medicare patients and also to shorten the length of time that those patients stay in the hospital.

"The people responsible for operating the review system will not undertake to treat your injury or illness but they will control Medicare payments for services in our hospitals.

"As your physician I am concerned for your health. I am also concerned with the cost of services, but, I must place your health needs ahead of cost factors. This will mean, on occasion, a difference of opinion between myself and the PRO Program. I want to assure you that I am your advocate and will strive to act in your best interests regardless of the sometimes inflexible and inappropriate rules of the PRO.

"Please discuss these requirements and any other health care issues with me. Together we can solve this problem.

"Your physician—a member of the Medical Society of New Jersey."

(signed) Vincent A. Maressa
Executive Director

Pilonidal Cyst

June 11, 1985

Dear Doctor Krosnick:

It was with great interest that I read the article on pilonidal cysts written by Dr. Trooskin (May 1985). If Dr. Trooskin had used the operation of marsupialization on pilonidal cysts as described by Dr. Abramson, which is the second article in the bibliography, he would have been able to write an article on the procedure of choice. The surgeons in the Army had a vast experience with pilonidal cyst disease, and found that wide excision of any type was very disabling and costly. In addition, the recurrence rate was much higher than with marsupialization. It seems that we are going around in a circle—we are attempting to use more radical procedures when the simple marsupialization is the most efficacious treatment of pilonidal cysts. In addition, the disability after wide excision is approximately three times that after marsupialization. Marsupialization can be performed under local anesthesia on an outpatient basis. One point that has not been emphasized in the article is the care of the wound following surgery. It is important to shave the area weekly to prevent hairs from growing into

the healing wound. In addition, the patient who has healed requires special hygiene to the area, to prevent a recurrence, which consists of daily showering or bath with vigorous washing of the area to dislodge any hairs that have possibly begun to grow into the skin. I hope that anyone who has read the article does not get the impression that the two procedures described are the best procedures. As far as I am concerned, there is only one good procedure, and that is marsupialization as described by Abramson.

(signed) Stanley Edeiken, M.D.

June 25, 1985

Dear Doctor Krosnick:

Thank you for forwarding to me the letter by Dr. Edeiken concerning my article, "Pilonidal Cyst: Wide Excision and Primary Closure with an Advancement Flap," (*JMSNJ* 82:367-370, 1985). I am happy to see that it provoked some thought.

Dr. Edeiken advocates a procedure outlined in the second paper listed in my reference section by Abramson. When I became dissatisfied with the technique of wide excision and marsupialization, I considered the approach detailed by Abramson. After careful review of his paper, I rejected his approach because of patient inconvenience. The healing

time was three to six weeks; sitz baths and shaving were prescribed for all patients. The advantage of wide excision and closure with an advancement flap is that the time of healing is shorter and there is no need for sitz baths or long-term special efforts to shave or clean the precoccygeal area. There have been no recurrences in my series which by now is well over 20 patients followed for up to four years after operation. Wide excision with primary advancement flap closure requires a general anesthetic and a longer hospital stay, but does markedly reduce the period of disability and inconvenience for the patient.

(signed) Stanley Z. Trooskin, M.D.

Threshold Attainers

June 17, 1985

Dear Doctor Krosnick:

As an occupational medical physician, I appreciate, possibly more than most, the excellent opinion by Dr. Goldstone (*JMSNJ* 82:475-477, 1985). These Threshold Attainers and their referring attorneys should be uncovered and routed out—though it is doubtful that they will be—they are too close to the politicians.

(signed) A.D. Teaze, M.D.

BOOK REVIEWS

Annual Review of Medicine; Conn's Current Therapy; Current Emergency Diagnosis & Treatment; Hospital Paediatrics; Introduction to Medical Microbiology; Outpatient Urologic Surgery

Annual Review of Medicine, Volume 36

Creger, Coggins, Hancock (eds).
Palo Alto, CA, Annual Reviews, Inc.,
1985. Pp. 658. Illustrated. (\$27)

Annual Reviews, Inc. is a nonprofit scientific publisher established to promote the advancement of the sciences. The volumes are organized by editors and committees who invite qualified authors to contribute critical articles for review. This present volume consists of 48 articles with a spread through almost every facet of the basic sciences and clinical problems of medical and surgical practice.

Each subject begins with a brief extract to stimulate interests and ends with a detailed summary, extracts, and citations or references.

It is reasonable to expect that by reading the introductory comments and summary statements, one should develop enough interest to return and study the entire substance of the article.

Annual Review of Medicine would fit very well in any medical school or hospital library.

Harry M. Poppick, M.D.

Conn's Current Therapy

Robert E. Rakel, M.D., (ed). Philadelphia, PA, W.B. Saunders Company, 1985. Pp. 1020. (\$45)

The 1985 *Conn's Current Therapy*, edited by Robert E. Rakel, M.D., is the latest in the distinguished series of books of the same title. The format for these publications has remained remarkably consistent over the years. In each instance, the editor assembled a group of nationally and internationally prominent experts and charged them with the responsibility of writing a concise treatise covering their area of expertise. These individual efforts then were editorially assembled, by specialty or organ system, into an organized presentation utilizing a textbook format. Refinements of this process over the years have resulted in a readable and informative publication, with this latest edition undoubtedly the most successful to date.

Despite this success, however, there are some significant restrictions imposed by this format which may limit the usability of this text for certain individuals. In the first place, any book which relies on a multiplicity of authors is subject to differences in writing style which might result in some compromise in continuity. In addition, different authors approach a topic differently. Although it is obvious that there were significant editorial constraints placed upon the contributors, and an attempt was made at editorial consistency, nonetheless, there is sufficient disparity from topic to topic to create a certain amount of disharmony in the final product.

Also, it apparently was an editorial decision to completely eliminate illustrations. I believe that this is unfortunate, as in certain areas (such as local obstetrical anesthesia) some limited illustrations may have rendered the text more readable.

One final comment needs to be made concerning the applicability of this publication. Although all topics are addressed sufficiently to provide the practitioner with a ready reference or resource, the text does presuppose a significant knowledge of clinical medicine in order for it to be adequately utilized. It does provide a comprehensive and ready reference for the practitioner and it

allows for an instant update in a situation where a practitioner needs immediate information on a topic where the diagnosis is reasonably certain.

With these caveats in mind, I would recommend to the clinician that a recent edition of *Conn's Current Therapy* be a part of a complete medical library. It is authoritative, factual, and as up-to-the-minute as a textbook can be. It is reported in a reasonable and usable fashion and, as such, is a valuable edition to the medical literature.

Joseph A. Lieberman, III, M.D.

Current Emergency Diagnosis & Treatment

John Mills, M.D., Mary T. Ho., Patricia Salber, M.D., Donald D. Trunkey, M.D., (eds). Los Altos, CA, Lange Publications, 1985. Pp. 864. (\$28)

This 864-page second edition text is an updated version of one published in 1983. The first edition was the finest text and reference book in emergency medicine that I have read in the many years I have been involved in emergency medicine. This text is in that same category.

All aspects of emergency medicine are covered in an excellent manner. No space is wasted, including the inside and back covers that list drugs most commonly used intravenously and a conversion table of drug doses in mg/kg to the total dose for the patient.

The text is especially noted for the immediate management of life-threatening problems regardless of the status of diagnosis or the need for the diagnosis. This is most important when a physician first sees an acutely ill patient. In order to facilitate quick reference, the overall table of contents of each chapter is supplemented by detailed lists of chapter contents at the beginning of each chapter. At the end of each chapter is a list of selected references concerning each subject.

The narrative portion of the subject matter is covered adequately with tables; diagrams and radiograms are excellent.

This book should be in every hospital emergency department, used as a reference by every emergency or general practice physician, and as a teaching text in medical schools.

Jack R. Karel, M.D.

Hospital Paediatrics

A.D. Milner and D. Hull. New York, NY, Churchill Livingstone, Inc., 1984. Pp. 412. Illustrated. (\$40)

The objective of the authors is to provide busy house officers with a clear, outline form of material necessary to evaluate, diagnose, and manage many pediatric problems. The authors, with subspecialist collaborations, work out of Children's Hospital, Nottingham, England.

A book of this type, not handbook in nature, provides basic information to the house staff and it is incumbent upon the trainee to seek out larger textbooks and reference articles for a fuller approach to the problems addressed.

The content of the book is broken down into chapters dealing with the skin, ENT, heart, gut, airways, and lungs. The material is enhanced by x-ray photos and figures. Within the didactic framework of the presentation, there is some digression to physical diagnosis and listings of causes of, for example, hepatomegaly.

Although the material presented primarily in "pearl" form should be well appreciated in the United Kingdom, an analysis of its content in terms of diagnostic approach and management would lead to a qualified recommendation to its usage by house staff in the United States. For example, the diagnosis of lead poisoning does not mention EP levels as a diagnostic tool. Also, under the treatment for lead poisoning, penicillamine is mentioned as an adjuvant (not FDA approved).

Another constructive critique is the title of the book. From the title, one would get the impression of inpatient hospital pediatrics; however, many of the problems dealt with are strictly outpatient management solutions.

Frank C. Vanore, M.D.

Introduction to Medical Microbiology

Marcus M. Jensen and Donald N. Wright. Englewood Cliffs, NJ, Prentice-Hall, Inc., 1985. Pp. 529. (\$29.95)

Jensen and Wright from Brigham Young University have written a concise introductory text of medical microbiology in 41 chapters. This hard-covered, maroon-colored book is written exclusively for the beginning medical student who fears being overwhelmed with new data. Using many nice schematic drawings and tables, one can visualize major components of microbiological agents. The classification of the bacteria, viruses, and fungi are simplified nicely. The introductory first chapter on the history of microbiology provides a concise outline of great discoveries and their authors. The clinical pictures are poor and are in black and white. There is no bibliography, which is a very negative factor. Very little is given about the important retroviruses. As one reads the book, one senses that Jensen and Wright are good teachers, and this is their course material. It does not measure up to the Lange series and other books on microbiology. I personally

would not want this text in my library.

Leon G. Smith, M.D.

Outpatient Urologic Surgery

Keith W. Kaye, M.D., (ed). Philadelphia, PA, Lea & Febiger, 1985. Illustrated. Pp. 312. (\$42.50)

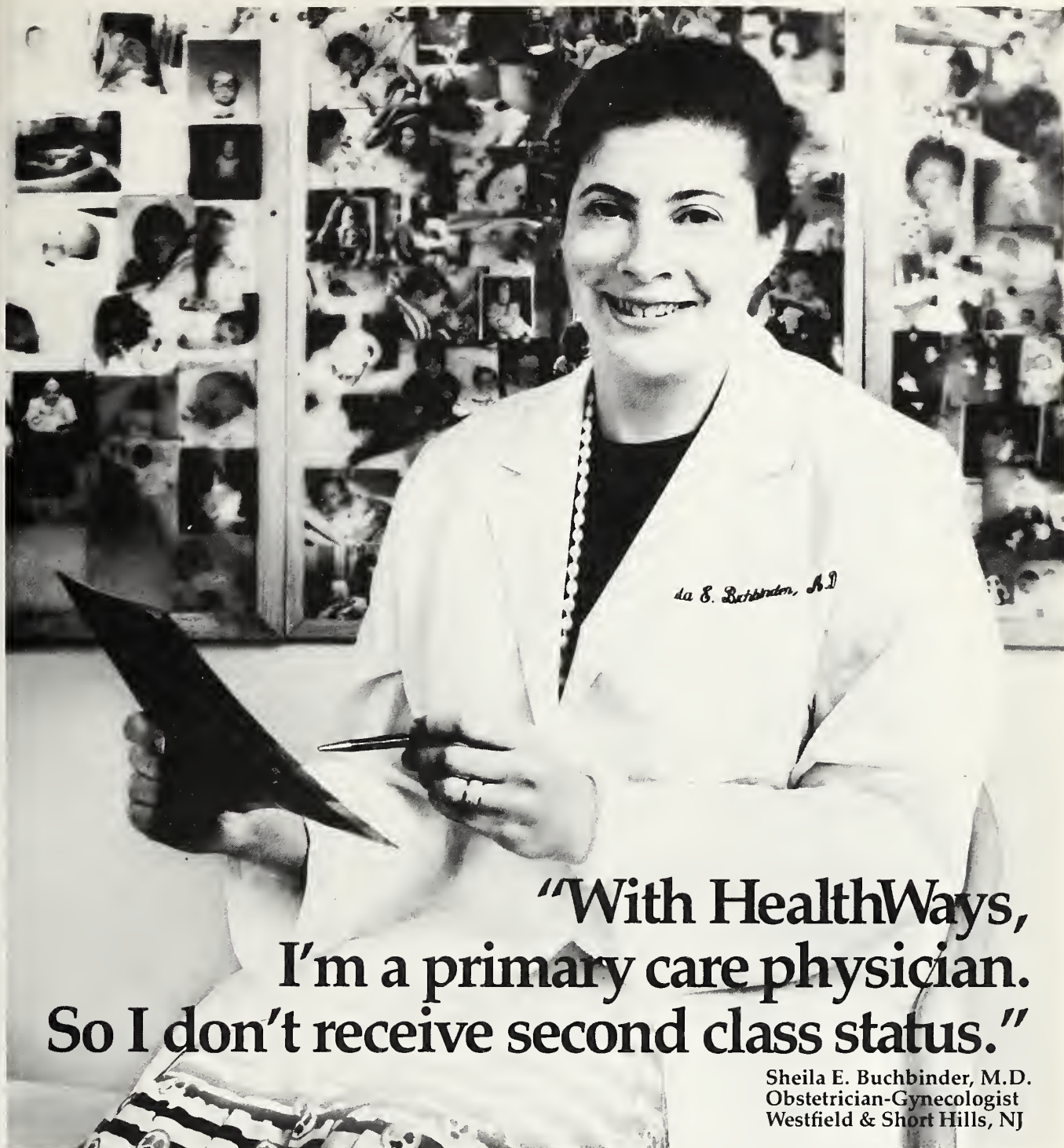
Outpatient prostatectomies? Can they be serious? The pressure is on for ever-decreasing hospital stays, and this book is a good and very timely guide to the accomplishment of this goal.

Dr. Kaye and his distinguished contributors discuss everything regarding outpatient urologic surgery. There are sections on the surgical unit, finances, legal risks, anesthetic techniques, urodynamics, endoscopy, endourology, invasive radiologic procedures, renal biopsies, surgery including orchidopexy, cystostomy, implantation of penile prostheses, needle bladder suspension for female stress incontinence, transurethral prostatectomy, and a host of less formidable operations.

Urologists have to decide that for any given procedure on any given patient, "Is there any real reason why this patient would be better off as an inpatient?" and "Is this truly the best and safest way to do it?"

Hospitals seem to be on the way to pricing themselves out of existence, especially in a political climate that favors bullets over bandages, and outpatient surgery does appear to be the wave of the future. We will need some guides to riding this wave, and this book is a good one.

Robert Zufall, M.D.



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I'm a primary care physician.
So I don't receive second class status."**

**Sheila E. Buchbinder, M.D.
Obstetrician-Gynecologist
Westfield & Short Hills, NJ**

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As far as I'm concerned, HealthWays is not only first class for my patients, it's first class for me."

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Woltz***

Dr. Daniel B. Eck

At the age of 73, Daniel Burrows Eck, M.D., died on June 2, 1985. An orthopedic surgeon for the past 40 years, Dr. Eck had been a staff member of Saint Michael's Medical Center, Newark; East Orange General Hospital; Overlook Hospital, Summit; and Morristown Memorial Hospital. Born in 1912 in East Orange, Dr. Eck received his medical degree from Creighton University, Nebraska, in 1938. Dr. Eck was a Fellow of the American College of Surgeons, a Diplomate of the American Board of Orthopedic Surgery, and a member of our Essex County component.

Dr. Albert Grunberg

Albert Grunberg, M.D., a retired urologist, living in Delray Beach, Florida, died in February of this year. Born in 1915 in Germany, Dr. Grunberg received his medical degree from the Faculty of Medicine, Uni-

versity of Rome (Italy) in 1940. He emigrated to the United States, and established his practice in East Orange. Dr. Grunberg was a member of our Essex County component, and of the American Medical Association. He had been affiliated with Saint Barnabas Medical Center, Livingston; East Orange General Hospital; St. Mary's Hospital, Orange; and University Hospital, Newark. Dr. Grunberg was board certified in his specialty, and was clinical assistant professor in urology at UMDNJ-New Jersey Medical School, Newark.

Dr. Theodore S. Heineken

At the age of 81, Theodore Stanley Heineken, M.D., a member of our Essex County component, died on May 23, 1985. Born in Burlington, Dr. Heineken received his medical degree from Temple University, Pennsylvania, in 1929. An internist, Dr. Heineken was affiliated with The Mountainside Hospital, Montclair. Dr. Heineken was a member of the American Medical Association, a Diplomate of the American Board of Internal Medicine, and a Fellow of the American College of Physicians. In 1979, Dr. Heineken was awarded MSNJ's Golden Merit Award for 50 years of service to the medical community.

Dr. Edward R. Levitzky

Edward Levitzky, M.D., a pediatrician in Rahway, died on May 28, 1985. Born in 1919, in Philadelphia, Dr. Levitzky was awarded a medical degree from Albany Medical College, New York, in 1944. A private practitioner, Dr. Levitzky was affiliated with Rahway Hospital, and Newark Beth Israel Medical Center. Dr. Levitzky was a member of our Union County component and a Diplomate of the American Board of Pediatrics. He also was a Clinical Associate Professor at Rutgers Medical School, New Brunswick. Dr. Levitzky served as a captain in the Army from 1946 to 1948.

Dr. G.M. Longbothum

A member of our Union County component and of the American Medical Association, George Marshall Longbothum, M.D., died on June 1, 1985. Dr. Longbothum was an internist affiliated with Muhlenberg Hospital, Plainfield. Born in

1921, in Plainfield, Dr. Longbothum received his medical degree from Cornell University Medical College, New York, in 1945. In 1971, Dr. Longbothum received MSNJ's Golden Merit Award for 50 years of service to his medical community. Dr. Longbothum was an United States Army captain, serving from 1946 to 1948.

Dr. Arthur D. Seybold

Arthur Denton Seybold, M.D., died on May 31, 1985. A retired member of our Union County component, Dr. Seybold was a family practitioner in South Plainfield. Dr. Seybold was awarded a medical degree from the University of Michigan Medical School in 1927. A private practitioner, Dr. Seybold was affiliated with Muhlenberg Hospital, Plainfield, during his lengthy career. Dr. Seybold was a Fellow of the American College of Surgeons and a member of the American Medical Association. In 1977, Dr. Seybold was honored with MSNJ's Golden Merit Award honoring his 50 years of service to the medical community.

Dr. Sidney Woltz

A Union City internist and diabetologist, Sidney Woltz, M.D., died in Christ Hospital, Jersey City, on May 22, 1985. Born in 1916, Dr. Woltz received his medical degree from Long Island College of Medicine, New York, in 1939. He returned to his native city to establish his practice, and became a member of our Hudson County component and of the American Medical Association. Dr. Woltz was a Fellow of the American College of Angiology, of the American College of Nutrition, of the American Diabetes Association, of the American College of Nursing Home Administration, and of The Academy of Medicine of New Jersey. He was director of continuing medical education and chief of the diabetic section at Christ Hospital for many years. Dr. Woltz had served as medical director of the Palisades Nursing Home, Guttenberg, and of the Teaneck Nursing Home. For the last 30 years, he had been medical director of Durotest Corporation, North Bergen. Dr. Woltz had served on MSNJ's Council on Medical Services and he had been chairman of the Diabetes Committee of the Hudson County Medical Society for 30 years.

AUTHOR INFORMATION

Style Sheet

The Journal is the official organ of the Medical Society of New Jersey. The goals of The Journal are educational and informational. All material published in The Journal is copyrighted by MSNJ.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

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Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the

source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

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The **summary** of the article should not exceed 250 words; it should contain only essential facts.

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1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

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Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

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The Future of Malpractice Suits

California Trial Lawyers Mount Assault; Malpractice Suits Are Going Too Far; Did You Know?

Rebuffed in four separate attempts to topple key provisions of California's strong malpractice tort reform legislation as unconstitutional, the California Trial Lawyers Association now seeks to repeal the controversial statute. State legislation (SB-520) would "negate the strongest tort reform legislation in the country" and "result in immediate and dramatic increases in premiums," the California Medical Association (CMA) says. Should the bill succeed in the California assembly, it would "precipitate another crisis just like the one ten years ago," warns CMA President Clarence S. Avery, M.D., San Leandro.

It was in California, little more than a decade ago, that the malpractice crisis erupted with attendant headlines and accompanying anguish for physicians and hospitals. Premiums shot up—in one carrier's case by 350 percent—and other companies fled the market. Physicians staged work slowdowns that bordered on strikes to publicize their plight. Then, in a special 1975 legislative session, a comprehensive package of tort reform—the Medical Injury Compensation Reform Act (MICRA or AB1xx)—was enacted. Since then, the California professional liability scene has been relatively stable when compared to some other areas of the nation. Many in the health care field attribute the improved professional liability climate directly to the legislation.

"Specifically, passage of SB-520 would repeal the provisions of AB1xx which allow for mandated periodic payments, sliding scale attorney's fee limitations, the collateral source rule, and the \$250,000 limitation on pain and suffering awards," said a memo sent to California physicians. "Additionally, it would repeal the statute of limitations on suits brought on behalf of minors."

Ironically, major provisions of MICRA have been upheld in four separate court tests. Periodic payments were upheld in *English v Los Gatos Community Hospital* (MLM, August 1984) and elimination of third-party liens in *Barme v Wood*. This year California's Supreme Court upheld a sliding scale of contingent fees in *Roa v Lodi Medical Group, Inc.* and changes in the collateral source rule and a \$250,000 limit on noneconomic damages in *Fein v Permanente* (MLM, March 1985).

Trial lawyers sought rehearings on both *Roa* and *Fein*. A rehearing on *Fein* was rejected and a decision on a rehearing of *Roa* was expected. So incensed are the trial lawyers over the limits on contingency fees that Melvin Belli's law firm has submitted a ballot initiative to the California secretary of state for certification. If enough signatures can be secured, a constitutional amendment would go before the voters seeking repeal of the law in 1986. The initiative also would bar the legislature from limiting the dollar amount of judgments or lawyers' fees and permit lump sum rather than periodic payments of awards, CMA reports. Once incorporated into the state constitution, these MICRA provisions now on the books would be nullified and very difficult to reinstate.

Meanwhile, a crisis committee of CMA's Task Force on Professional Liability was created in March. One of its major objectives will be to defend MICRA against attack. At its meeting earlier this year members directed the CMA to develop one or more voter initiatives to address the principal issues of escalating professional liability problems in the state. A CMA-sponsored bill to change the state's joint and several liability to several liability for noneconomic damages is advancing in the state legislature. This change would prevent plaintiffs from seeking the "deep pocket" defendant, apportioning liability on the basis of individual defendants' relative fault, CMA says.

In March, the *Washington Post* editorialized on malpractice and state reform, concluding that California's reforms, now upheld by the state's highest court, are major changes. If they prove effective they will provide a good model for other states, said the newspaper. "Clearly, California will be the state to watch." (*Medical Liability Monitor*, Vol. 10, No. 5, May 20, 1985.)

MALPRACTICE SUITS ARE GOING TOO FAR

In nearly every profession, advances are being made, but not all of them are good. In the field of medicine, for example, many doctors live under the constant threat of malpractice suits, not because of something

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Director of Special Projects.

they have done wrong, but increasingly because of something they have not done at all.

Doctors now are being sued for something called "wrongful birth." Medical practitioners may be accused of prenatal negligence, or failure to advise a parent of the risk of giving birth to a defective baby. Some parents are claiming that had their doctor indicated the possibility of significant birth defect because of the mother's age, for example, the woman probably would have had an abortion. Some doctors have been held liable and must pay the medical and other costs of caring for the defective child.

If that is not bad enough, doctors sometimes fight suits stemming from another concept that appears questionable, at the very least. The state supreme courts in New Jersey, Washington, and California have ruled that suits brought against doctors on behalf of a child with extraordinary birth defects can lead to a finding of wrongful life. In these instances, doctors may not be responsible for the birth defects, but can be held responsible for allowing a defective baby to be born into a life of very special needs and care.

Things seemed far more simple years ago. A doctor did his or her very best to create a healthy climate for birth and advised potential mothers on how to care for themselves during and after pregnancy. Doctors often warned pregnant women about possible problems, but it usually was not a matter for worry.

Among some doctors, worry about malpractice is becoming an obsession. Simplicity in medicine has given way to legal complexities. With new knowledge concerning birth defects, doctors are being held accountable for many decisions they are not always in a position to make.

One doctor, who has been practicing medicine for many years, told me that when he entered the field, malpractice protection cost him \$180 a year. Recently, he has been spending more than \$18,000 annually to insulate himself against the possibility of massive suits.

The means to detect hereditary and other fetal risks early in pregnancy are leading to a plethora of lawsuits that leave many doctors vulnerable. Some practitioners, in cases of doubt, are advising abortions to avoid trouble.

According to the *Wall Street Journal*, the Catholic Health Association ran an ad showing a baby about to be crushed by a gavel labeled "court decisions." The ad stated, "We in Catholic health care don't believe that human life is ever wrongful. We believe that even if the infant is born with defects, birth is rightful—a living miracle to be respected and cherished, not grounds for a lawsuit."

Years ago, courts routinely rejected the idea of wrongful birth suits, mainly because before abortions

were approved by the Supreme Court in 1973, the destruction of a fetus was not a legal option.

In one case, the California Supreme Court upheld the right of a married couple to sue on behalf of a girl born deaf. The action was directed against a doctor who "failed to detect the hereditary deafness of the child's older sister and to advise the parents that subsequent pregnancies could result in the birth of deaf children." The parents who filed suit claimed they would have avoided pregnancy had they been advised of the possibility of another deaf infant.

If court decisions continue the way they are headed, they may soon lead doctors to function somewhat like police officers, reading a pregnant woman her medical rights from a printed card and insisting that patients sign a statement that they have been warned about every conceivable contingency connected with the possibility of defective birth. As ridiculous as it may sound, it may become necessary for doctors to place lawyers on their payrolls before agreeing to handle pregnancies.

My view is not that doctors should not be held accountable for serious errors. But neither should they be victimized by a new greed on the part of people who hope to get rich on the strength of unreasonable court decisions. The burden or risk of pregnancy should remain with the parents, not with doctors who do their jobs as well as one should reasonably expect. Certainly, I'm no expert, but I know enough about medicine to realize that problems in pregnancy can occur at any time during gestation.

I hope the day is not near when a woman who learns she is pregnant, consults a lawyer before she visits an obstetrician. (*The Philadelphia Inquirer*, June 10, 1985, an editorial by Claude Lewis.)

DID YOU KNOW . . .

Dental anesthesiologists are being forced out of the field by rising costs of malpractice insurance. Charles Cohen, D.D.S., chief of periodontics at New York's Mt. Sinai Hospital told a National Institutes of Health consensus conference on dental anesthesia? Dr. Cohen said rates climbed from \$3,200 to \$27,000 annually in just one year in New York. (*Medical Liability Monitor*, Vol. 10, No. 5, May 20, 1985.)

MIIENJ reports that it has stopped selling any new policy with a limit of less than \$500,000 per incident and \$1.5 million aggregate? All insureds with former \$100,000 limits have been renewed at \$200,000 for 1985 and the \$200,000 designation will be discounted after February 1, 1986. About 88 percent of its policyholders are now taking the maximum primary coverage of \$1/\$3 million. Supplementary high limits insurance up to \$4 million also is available and increasingly popular.

Status of PRO and MSNJ

President Fioretti has deemed PRO to be a major concern; he has created a permanent PRO Committee to look into the situation.

Preadmission review and certification, as well as retroactive evaluation and the development of so-called "Norms, Standards and Criteria" are the law of the land in accordance with Title XVIII of the Social Security Act. During the last regime, President Frank Y. Watson appointed an Ad Hoc PRO Criteria Committee whose mandates were:

1. To review carefully the criteria promulgated and imposed by the PRO of N.J., Inc.
2. To delineate deficiencies, aberrations, unreasonable or unattainable standards, and unfair guidelines.
3. To bring these reviews to the attention of the Executive Director, the medical directors, and the Board of Trustees of the PRO of N.J., Inc.
4. To negotiate corrective modification of faulty criteria with the PRO of N.J., Inc.

MSNJ, as requested by its Board of Trustees, was allowed representation on the PRO of N.J., Inc. Criteria Committee and a member attended and participated in two meetings of that committee. MSNJ also requested official representation as a member or observer on the Board of the PRO of N.J., Inc., but this was denied.

By now, most physicians who are affiliated with a New Jersey hospital have been made aware of the revised criteria approved by the PRO of N.J., Inc. Board of Trustees and the Health Care Finance Administration (HCFA). It is noteworthy that a statement appears at the bottom of each criterion as follows: "These criteria are for use by nonphysician reviewers to screen records for subsequent physician review only, and do

not constitute standards of care. They will be continuously re-evaluated and modified as needed."

Although this statement may provide some small measure of comfort to medical practitioners, it does not make the process less threatening or onerous. Although the comment was made that the criteria are not engraved in marble, one critic said they at least are set in wet concrete which inexorably will go on to harden. Furthermore, a number of items relating to PRO were brought before the 219th Annual Meeting of the House of Delegates:

- AMA delegation, re PRO regulation.
- Executive Director's report, re appeal or alteration of PRO via litigation.
- Resolution #2, re employment by PRO while active as an MSNJ officer, council member, or committee member.
- Resolution #26, re membership on PRO of N.J., Inc. Criteria Committee and several matters related to criteria.
- Resolution #29E, re appeal hearings and the appeal process.
- Resolution #30E, re denial of "prior approval plans" and the responsibility of the physician for adverse outcomes.
- Resolution #14 (Preadmission Review/Certification), re public relations campaign, notification of state and national legislators of the MSNJ position, and presentation of a similar resolution to the AMA House of Delegates.

All of the above items were adopted or filed. However, a report of legal counsel to the MSNJ Board of Trustees was as follows: "The House of Delegates adopted Resolution #14 which contained five resolved sections. The third called for legal counsel to investigate and report on the advisability of a legal remedy to the PRO preadmission review/certification process. In order to successfully litigate against the program which is in place in New Jersey, it will have to be shown that the criteria used and decisions reached are medically inappropriate. Further, it must be established that as a result of the process, patients have been denied appropriate treatment and have suffered documented injury. I have had no evidence presented to me that would, in my opinion, support successful litigation on this issue. If such evidence is forthcoming, I promptly will present it to the Board for authorization to proceed."

On the basis of the letters and documents submitted to the Ad Hoc Committee, I must agree with counsel's conclusion. To date, a generic classification of complaints falls in the categories of nuisance or "nit-picking" letters from PRO to physicians, impolite and unreasonable attitudes by a reviewing physician, and complaints about the timing of preadmission tests.

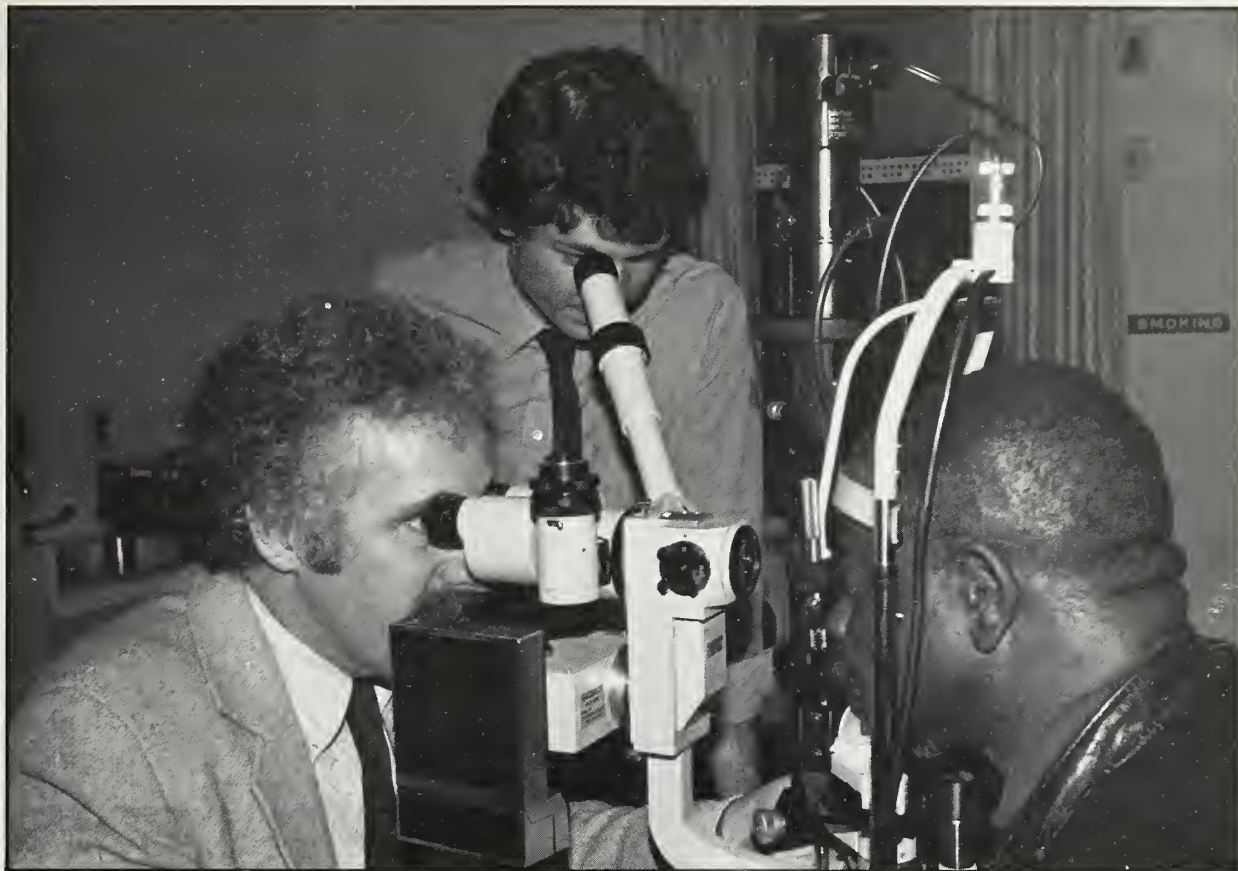
A major concern is the fact that denial of approval of preadmission certification by the PRO represents a transaction between the PRO and the patient, not between the PRO and the physician. The physician who recommends to a patient who is insured by Medicare that he enter the hospital for treatment of diabetes is obliged to complete a detailed form and request preadmission approval by the PRO. Whether the PRO approves or disapproves the admission, that is a matter between the insurer (Medicare) and the insured per-

son (the patient) and not between the PRO and the physician. When denials occur, it is left for the physician to explain to his patient. This clearly is not fair because it again places a barrier between the physician and his patient which is the responsibility of government, which made the law, and PRO of N.J., Inc., which is paid to implement the law. The remedy for this unacceptable technique is for the PRO to clearly, simply, and directly explain to the Medicare recipient and his family why the PRO is denying the hospital admission.

President Ralph J. Fioretti has deemed the PRO to

be a major concern so he has replaced the Ad Hoc PRO Committee with a permanent PRO Committee with staff assistance. The functions and duties of the Committee will be delineated. In the meantime, physicians who encounter cases in which "the criteria used and decisions reached are medically inappropriate" and "as a result of the process patients have been denied appropriate treatment and have suffered documented injury" should promptly report those cases to the PRO Committee for evaluation and for attention by legal counsel.

A.K.



THE Nd:YAG LASER IN OPHTHALMOLOGY

The Neodymium:Yttrium-Aluminum-Garnet (Nd:YAG) laser was developed in the 1970s primarily through the research of Dr. Aron-Rosa of Paris.¹ It became apparent that a noncauterizing mechanical laser could perform surgical ocular tasks in a noninvasive manner. After many years of research, ophthalmologists were provided with a clinical Nd:YAG laser in 1982.

The Eye Institute of New Jersey, in its continuing effort to provide the latest in technological advances, obtained an initial model (Figure 1) in April 1983. This paper reports the results of the posterior capsulotomies in the first 449 eyes treated with the Nd:YAG laser with at least a three-month followup.

MATERIALS AND METHODS

The American Medical Optics Nd:YAG model #YAG 100 was used in treatment of 1,000 eyes with various ocular conditions over a 15-month period. The unit was made available to all ophthalmologists in New Jersey. Training sessions were established and 101 ophthalmologists were certified. The first 449 eyes which met the criteria of a thickened posterior capsule

and 3-month postoperative followup are included in this study.

These cases included eyes with or without intraocular lens implants. All cases were treated according to a protocol approved by the Food and Drug Administration which included training each ophthalmologist in the proper laser technique. Visual acuity was used as the standard of success. Measurements of the vision were taken preoperatively and at three months postoperatively. Complications were derived from the operative summary and postoperative evaluation forms. This paper reports the results in 449 patients with at least three months' postoperative follow-up visits.

*From the Department of Ophthalmology, UMDNJ-New Jersey Medical School where Dr. A. Cinotti is Professor and Chairman, Dr. Maltzman is Clinical Associate Professor, and Dr. D. Cinotti is Clinical Assistant Professor. Mr. Shapiro is a medical student at UMDNJ-New Jersey Medical School. Correspondence may be addressed to Dr. A. Cinotti, Eye Institute of New Jersey, 15 South Ninth Street, Newark, NJ 07107. This project was funded in part by the Lions Club of New Jersey.

ALFONSE A. CINOTTI, M.D., BARRY A. MALTZMAN, M.D., DONALD J. CINOTTI, M.D., ELI SHAPIRO, NEWARK*

LASER IN OPHTHALMOLOGY

The Nd:YAG laser is one of the most exciting developments in ophthalmology. Used primarily for opening thickened posterior capsules following extracapsular cataract surgery, the Nd:YAG laser is well accepted. We emphasize that cataracts are not removed by lasers, but by conventional incisional surgery.

RESULTS

Data analysis demonstrated that 87.9 percent of the subjects undergoing discissions of posterior capsules had improved vision (Figure 2). This corresponds to an 88.4 percent improvement reported by Keates in 526 cases with a six-month followup.² Visual acuity of 20/30 or better was achieved in 48.8 percent of the eyes. Another 23.9 percent had vision between 20/40 and 20/60 and 13.5 percent had postoperative vision between 20/70 and 20/100 (Table 1). In 27.7 percent of the subjects, significant preoperative ocular path-

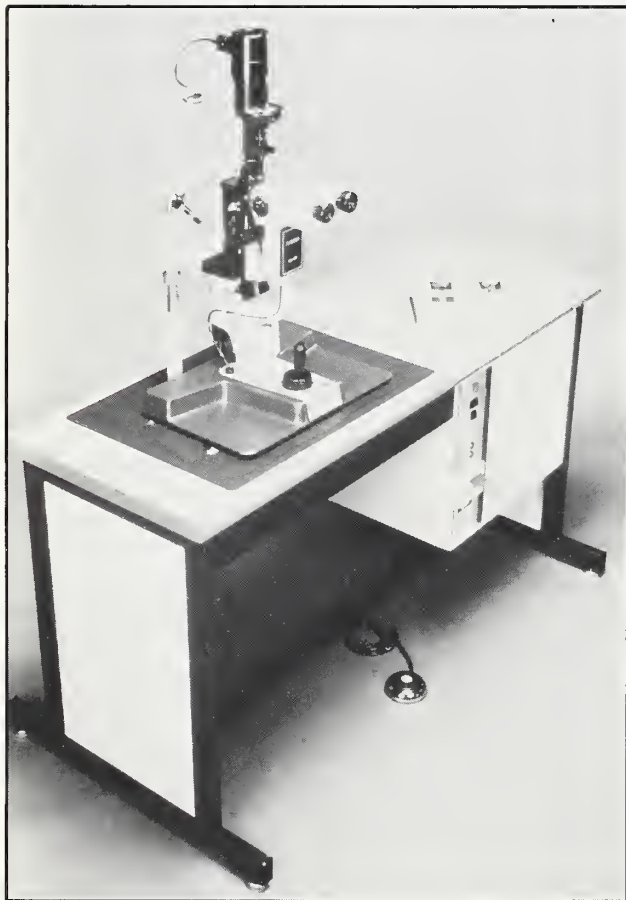


Figure 1—The AMO Nd:YAG laser.

ology was present (Table 2) which had some effect on the postoperative visual acuity.

The most important and frequent complication was a transient rise in intraocular pressure (IOP) which occurred in 54 patients (12 percent). Most of these increased pressures occurred within 24 hours of the laser surgery and returned to normal without treatment. In 9 patients (2 percent), the rise in IOP was over

28 mm/Hg and required antiglaucoma therapy. All responded to therapy, and there was no ocular damage. A mild iritis was found in 7 percent of the eyes, again without any lasting sequelae. Eight percent of the eyes had pitting of the intraocular lens as a direct result of laser energy striking the lens.

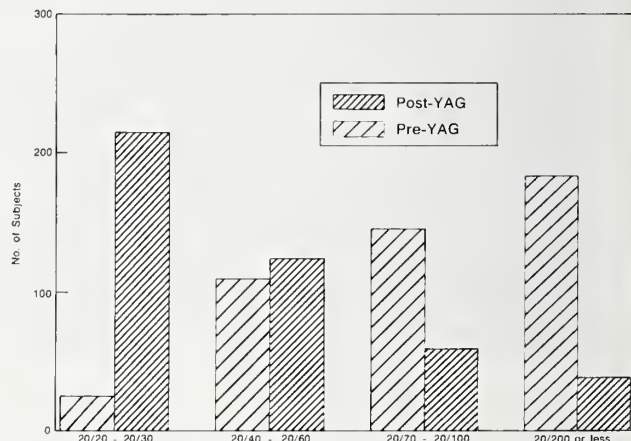


Figure 2—Graph showing the improvement in vision from pre- to post-Nd:YAG laser.

DISCUSSION

Lasers have been used in ophthalmology for the last 20 years. One of the earliest to gain acceptance and provide significant clinical benefit was the argon laser. This gas laser was first used in the treatment of diabetic retinopathy and retinal tears. Later, it became the procedure of choice in producing iridotomies in angle closure glaucoma. Most recently, it has been

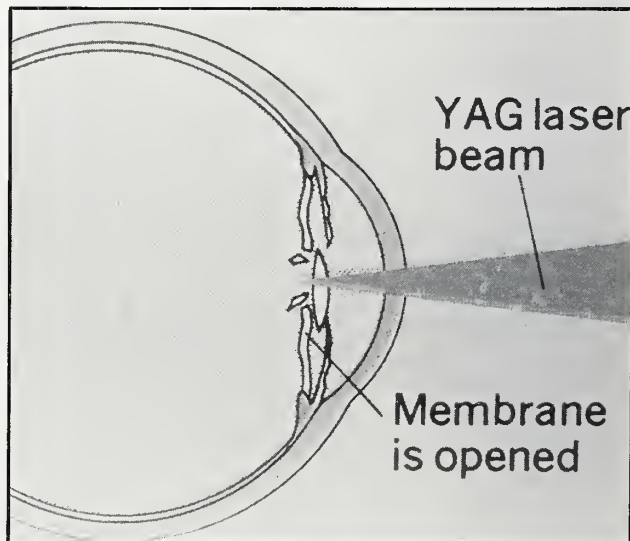


Figure 3—Intraocular implant and opaque membrane.

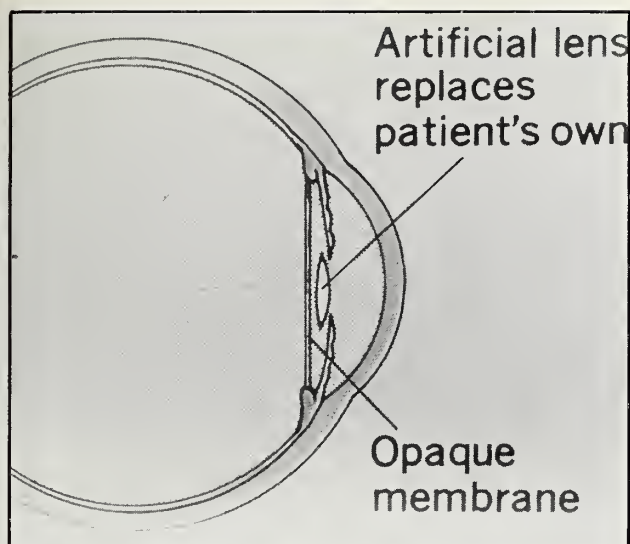


Figure 4—Microexplosion creating an optical opening in posterior capsule.

used in place of invasive surgery for open angle glaucoma.⁵⁻⁷ Argon and krypton lasers have been used effectively in the treatment of a small percentage of eyes with macular degeneration which is the most common cause of visual impairment in our aging population.^{8,9}

The indications for Nd:YAG laser in ophthalmology are: opening secondary membranes (posterior capsule thickening); cutting anterior vitreous strands; cutting posterior vitreous strands; anterior capsulotomy (prior to cataract surgery); releasing anterior synechiae; and iridectomy.

It is important to mention that all cataract surgery requires conventional primary invasive surgical techniques. The use of the Nd:YAG laser to open up the anterior capsule prior to traditional invasive (knife incision) extracapsular surgery is not a standard practice in the United States.

The Nd:YAG laser most commonly is used in ophthalmology to perform posterior capsulotomies. Following extracapsular cataract extraction, the capsule of the cataractous lens is left intact in the eye. This posterior capsule forms a very natural and physiologic barrier between the anterior and posterior chambers (Figure 3). In the majority of eyes, the capsule remains clear and enhances the health of the eye. It also serves as an excellent and natural backdrop against which an intraocular lens may be implanted with safety.

However, it is accepted widely that 20 to 30 percent of these posterior capsules will thicken in the years following the cataract surgery.³ Before the Nd:YAG laser, it was necessary to open the capsule either with needle or knife, an invasive procedure not without risks. The Nd:YAG has made the procedure of opening the capsule safe, effective, and noninvasive (Figures 5A, 5B, 5C, and 5D). The Nd:YAG laser can deliver its mechanical disruptive microexplosions directly on this posterior capsule and create an excellent optical opening (Figure 4).

The results listed above are evidence of the efficacy

and safety of this surgical procedure. The 87.9 percent of eyes which showed visual improvement represent an interesting factor. Some of the eyes had dense secondary membranes of long-standing duration, either from trauma or from previous surgical complications. Because this procedure is noninvasive, these patients and their ophthalmologists wanted to learn whether visual improvement could be obtained. In a few, the membrane was too thick to open and in others the posterior segment was diseased badly and precluded a good visual result.

Transient intraocular pressure increase apparently is the most common complication of laser surgery but resolves quickly and without sequelae. Antiglaucoma

TABLE 1

*Visual Acuity (448 Completed Cases)
Pre- and Postlaser Dissection of
Posterior Capsule or Secondary Membrane*

Visual Acuity	No. of Subjects	
	Before	After
20/20-20/30	28 (0.6%)	218 (48.8%)
20/40-20/60	105 (23.5%)	108 (23.9%)
20/70-20/100	145 (32.6%)	60 (13.5%)
20/200 or less	170 (37.9%)	62 (13.8%)
Total	448 (100%)	448 (100%)

TABLE 2

Preoperative Conditions Affecting the Visual Results

Condition	Percent
Glaucoma	9.3
Macular Degeneration	6.4
Cystoid Macular Edema	3.3
Diabetic Retinopathy	2.4
Uveitis	2.0
Retinal Detachment	2.0
Amblyopia	1.7
High Myopia	0.6
Corneal Diseases	0.2
Total	27.9

TABLE 3

*Possible Complications from Nd:YAG Lasers
as Listed by the FDA*

• Cystoid Macular Edema	• Transient Pressure Rise
• Corneal Burn	• Vitritis
• Iris Burn	• Lens Dislocation
• Retinal Burns	• Retinal Detachment
• Macular Edema	• Macular Degeneration
• Secondary Glaucoma	

therapy was used in only 2 percent of the cases and was discontinued after a short period of use. The mild iritis which occasionally was noticed was self-limiting and again caused no sequelae.

Pitting of the intraocular lenses was caused by direct injury to the lens by a laser burst. These "pits" had no

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ill effect on the visual acuity when they occurred. The problem of pitting has been resolved by improved helium-neon focusing systems.

Other infrequent complications reported in the literature are listed in Table 3. One important complication is retinal detachment. Although retinal detachments occur after discissions of the capsule, the complication fortunately occurs with low frequency. When retinal detachments occur, they have not been shown to be due to retinal damage from the Nd:YAG laser. Because the Nd:YAG laser energy is created by the formation of a "plasma" bubble, most of the energy is dissipated rapidly at the point of mechanical breakdown. Also, because the Nd:YAG laser light can be focused with precision, a wide converging focusing lens is used to deliver the Nd:YAG energy. Therefore, at the sight of optical disruption the energy is not only rapidly dissipated but becomes unfocused and diffusely scattered. Several laboratory and clinical studies have shown that there is no energy delivered to the retina. There was no evidence of radiation damage to the retinal tissue in this series.



Figure 5A—Intact thickened posterior capsule.

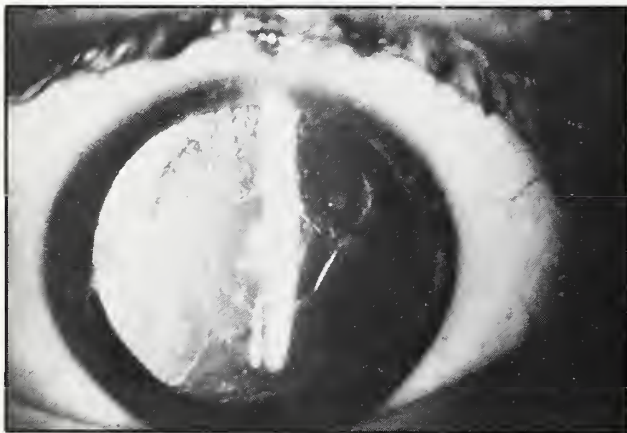


Figure 5B—Same capsule after Nd:YAG laser.

The Nd:YAG laser differs from the argon laser in several ways. The Nd:YAG laser is a solid state laser with the true lasing substance being neodymium. The argon laser is a gas laser. Solid state lasers tend to be more compact and more manageable in terms of physical design.

The argon laser operates in the wavelength area of 488 to 545 nanometers, which is in the blue-green

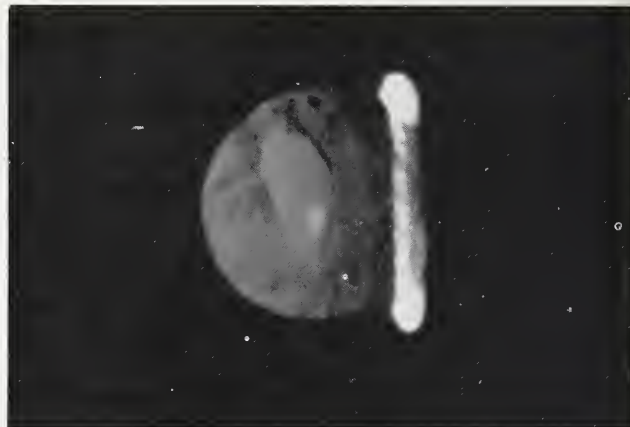


Figure 5C—A large opening in capsule following Nd:YAG laser.

portion of the visible spectrum, whereas the Nd:YAG laser has a light wavelength of 1064 nm. This is invisible and in the infrared spectrum.

Laser is an acronym for light amplification by stimulated emission radiation. The quantum theory of laser radiation states that a low energy source (such as a xenon-mercury lamp) is used to stimulate a lasing substance.⁴ The higher energy level of the lasing substance then is the source of the laser power. As the energy of the lasing substance is released, it can be focused by mirrors and be made coherent. This very powerful coherent laser light can be released from the mirror system by a triggering device. The emission of this high energy laser light then is focused through an optical delivery system (slit lamp) to treat target ocular tissue (Figure 6). The Nd:YAG laser (like the argon) readily can be adapted to a slit lamp and therefore can be used to treat ocular disease.

The mechanism of argon effectiveness is the release of thermal energy in pigmented tissue. The argon, therefore, acts as a cauterizing laser light. The Nd:YAG laser creates a mechanical disruption of ocular tissue. This occurs by the production of an intense electrical field and the formation of a partially ionized "plasma" gas bubble. The temperature rises dramatically within this gas bubble with the result of vaporization of tissue and the formation of a shock wave. The shock waves are microexplosions which can be focused with precision to interact with ocular tissue. The Nd:YAG

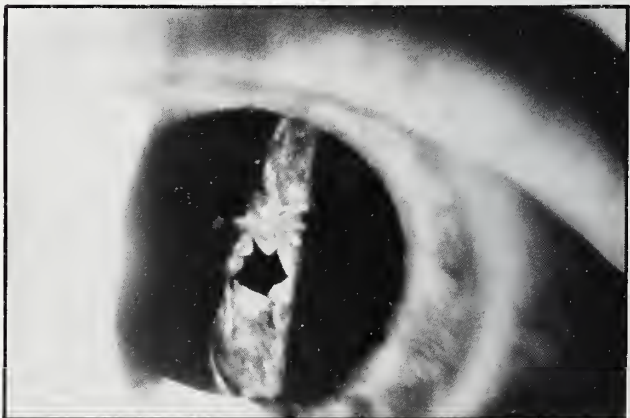


Figure 5D—A small but adequate opening.

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laser, therefore, has a mechanical action as opposed to the thermal mechanism of the argon laser.

CONCLUSION

Lasers are being used frequently in the daily management of ocular diseases. The argon laser is used for retinal and glaucoma disease and the krypton laser is used for macular degeneration. The Nd:YAG laser is

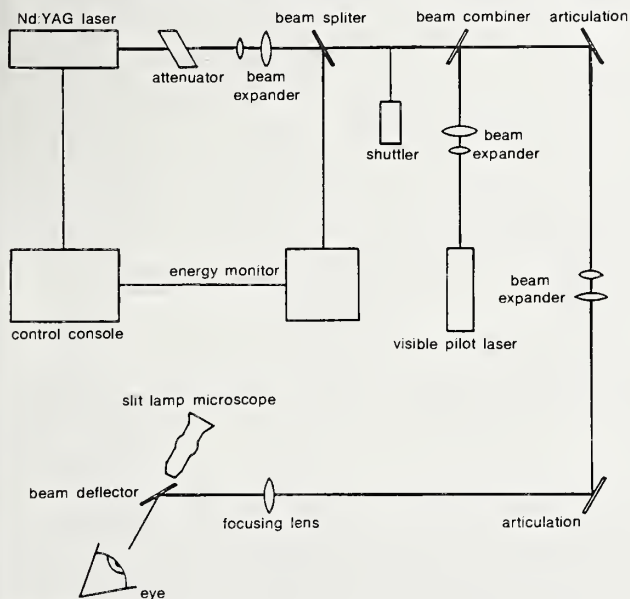


Figure 6—The primary components of a pulsed Nd:YAG laser system are shown here diagrammatically.

used primarily for opening thickened posterior capsules (membranes) noninvasively.

This paper is a review of these lasers and the excellent results achieved in the treatment of 449 eyes by 100 ophthalmologists at the Eye Institute of New Jersey: 87.9 percent of the treated eyes had improved visual acuity. There were few short-term complications proving the safety of a Nd:YAG capsulectomy.

Regionalization is a novel approach in medicine, especially where expensive equipment is needed. The point is emphasized that 100 surgeons could use the same machine in a central location maintaining fine quality and efficient patient care. Lastly, it is essential to emphasize that all cataract surgery requires invasive knife incisions and is not performed by laser.

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SELECTED JEWISH VIEWS OF LIFE AND MEDICAL PRACTICE

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We discuss some tenets of Judaism as they relate to life and the delivery of medical care including the issues of the definition of death, abortion, and triage. Attitudes toward specific interventions and practices are offered. Consultation with appropriate clergy and medical personnel is advised.

Among the fruits of modern medical technology are new-found challenges to Western values as explicated in the Judeo-Christian tradition. While we eagerly incorporate those devices which relieve pain and extend life, the economics of health care delivery are dictating a re-evaluation of those medical care needs which can qualify for resource allocation. Many clinicians find themselves in anomic situations, drawn as they are by reason of conscience and training to offer up-to-the-minute benefits to their patients, while increasingly being stressed by cost conscious administrators to curtail them. A culture lag is widening between the burgeoning technological sophistication and its social and ethical consequences which often inversely are related. This, in turn, may result in unsettled feelings throughout the doctor-patient relationship which can reduce clinical efficacy¹ as well as compliance.² An enhanced understanding of what traditionally has been considered right and wrong may be useful and can be derived from traditional Jewish theology.

In the following paragraphs, we will touch upon some of the generic principles using three specific issues as they apply to health care delivery: the definition of death, abortion and triage. This is followed by a synoptic perusal of the attitudes and orientations towards a sample of medical administrations which pose a challenge to traditional thought and values

either because of society's heightened awareness and/or their inherent novelty.

Fortunately, a cornucopia of literature exists which deals with many of the problems facing the contemporary clinician. This fund of knowledge is based upon Jewish law, otherwise known as the Halacha, whose roots are found in the Bible and its derivative, the Talmud, which in turn consists of both the Mishna and the Gemorra. The latter involves commentaries compiled between 450 B.C.E. and 500 C.E. by 2,000 scholars. A final score of Jewish law is the Responsa which involves the theological replies given to the queries in subsequent years. Many of the contributors to the Halachic literature were both physicians and rabbis, as exemplified by Maimonides.

Many American Jews, approximately 5,860,900,³ adhere to one of three major religious movements otherwise known as orthodox, conservative, and reform. Recent figures suggest that of this number, 1.35 million affiliate with the orthodox, 1.25 million are associated with the conservative, and 1.3 million are members of the reform movement.⁴ Orthodox Jews

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profess a faith in the Torah; it is immutable. Rabbis only aid in its transmission, in a teaching capacity, and may not alter it. Interpretation of the Torah is limited by precedent and principle. Reform Judaism, founded in 1824, is the only branch which has its roots on American soil. Its members believe that revelation is inspired and that it occurs in every age and for all mankind. They stress the notion of progressive development in religion and believe that each age summons forth the need for interpretation of as well as adaptation to the teaching of the Torah. Conservative Jewery was founded in 1875 as a reaction to orthodoxy. While believing in the Halacha, its adherents also emphasize, "Halachic literature by itself will not invariably provide a sufficient into the problems of our day," and "Where interpretation breaks down, legislation is required."⁵ One correctly concludes that orthodox followed by conservative and then reform Jews pursue progressively more liberal interpretations of the Torah and the Halacha. The most pervasive value in Judaism relating to life and health is the utter sanctity of the former and an all encompassing obligation to prevent disease, as well as to promote both physical and psychological well-being.⁶ Each individual life is considered sacred. Compromise of this position, it is held, is at the risk of the social and moral fabric of society. The sacredness of life is depicted in a passage in the Sanhedrin⁷ which, in discussing the creation of Adam as a single entity, equates the destruction of one human being with that of the entire human race and concomitantly the saving of just one individual with the rescue of the whole world. All laws in Jewish life, with the exception of the following three, are suspended if there was the slightest possibility that life could be extended for a mere fraction of a second: adultery, idolatry, and incest.⁸ The above suggests why euthanasia or mercy killing strictly is forbidden. Of critical importance is that while nothing may be done to hasten death such as the withholding of oxygen, intravenous feeding, and/or medicaments, it also is incumbent upon physicians not to artificially impede impending death.

This thinking is portrayed poignantly in the execution scene of Rabbi Hanina ben Tradyon.⁹ The Rabbi's students concerned about his agony, exhorted him to inhale the fumes thereby minimizing his pain by hastening death. The Rabbi refused to follow this course of action reminding his disciples that in so doing, his death indeed would be hastened but that only the Almighty permanently may terminate life. The execution ritual involved placing moistened woolen pads around Rabbi Hanina ben Tradyon's heart in order to heighten the agony of his ordeal. The executioner removed them in a fit of mercy. The Talmud related that the executioner's deed was very honorable and in full compliance with Jewish tradition and for the following reason: The wool represented an artificial impediment and as such could be removed legitimately, whereas inhalation is not such an impediment.

DEATH

The definition of death has been the subject of considerable thinking in view of technological advances which have the potential for maintaining cardiac

pulsation and respiration. The following is a list of criteria and standards of death required by orthodox Jewish thought:

1. Unresponsive coma: Any suspicion that the patient's coma is reversible and patient's unresponsiveness or unreceptivity must be followed up and ruled out.
2. Absence of spontaneous respiration and movement.
3. Absence of reflexes.
4. Absence of pupillary response to light.
5. Absence of oculoccephalic response.
6. Substance screening: Sufficient time must be allowed for determining the role of drugs acting on the central nervous system such as narcotic analgesics (morphine); barbiturates (secobarbital); sedatives (chloral hydrate); tranquilizers (phenothiazines); and the like.¹⁰
10. Radioisotope angiography to differentiate true brain death from other causes of profound coma also has been advocated.¹¹

In common practice, to elucidate the presence of brain death, the isoelectric EEG often is used today. There is at least one exceptional circumstance which may preclude treatment and this is exemplified by the moribund individual who, in the judgment of medical authorities, will not survive more than 72 hours. The obligation to heal terminates only at that point when all known medical means have been exhausted. The moribund individual may not have his jaws pryed, be anointed, washed, have any of his orifices plugged, have the pillow removed from him, be placed on the ground, or have his eyes closed.¹²

Reform rabbis considered this matter several years ago after having been presented with the following questions: "A patient has terminal cancer and has sunk into a deep coma. Only the artificial life-support systems are keeping him alive. Would Jewish tradition permit these systems to be shut off? What is the Jewish attitude toward euthanasia?"¹³ The approach agreed upon was that taken by the Ad Hoc Committee of the Harvard Medical School To Examine the Definition of Brain Death, which includes unreceptivity and unresponsiveness to externally applied stimuli and inner need and complete unresponsiveness; no movement or breathing covering a period of at least one hour; no excitable reflexes; and a flat electroencephalogram.¹⁴ These issues were reconsidered nine years later and came to be known as the Harvard criteria.¹⁵ The opinion concludes: "We would not endorse any positive steps leading toward death. We would recommend pain-killing drugs which would ease the remaining days of a patient's life. We would reject any general endorsement of euthanasia, but where all independent life has ceased and where the above-mentioned criteria of death have been met, further medical support systems need not be continued."

ABORTION

Abortion is another issue sincerely debated on both sides by people of equal intelligence, dedication, and high mindedness. While this practice is known to have existed throughout recorded history, and despite its repugnance to many, this procedure frequently is per-

TABLE

Traditional Views of Medical Practice

Medical Intervention/Practices	Attitude and Orientation
1. Abortion	Prohibited except when mother's life or health is threatened, e.g., in the presence of Tay-Sachs (mother's emotional health may be affected). Maternal indications, not fetal indications.
2. Amniotic Testing	Permitted only under specific conditions such as suspicion of Tay-Sachs.
3. Artificial Insemination	
Donor (AID)	Prohibited.
Husband (AIH)	Permitted.
Sperm banks	Prohibited.
4. Autopsy	Prohibited, except for purposes of acquiring specific medical information for the immediate benefit of others similarly afflicted and as required by law.
5. Circumcision	Mandated; must be performed according to Halachic principles; performed on the eighth day following the boy's birth unless medically contraindicated.
6. Cosmetic Surgery	Permitted in cases where deformity causes psychic and/or social isolation; may not be performed on the Sabbath.
7. Euthanasia	
Active	Prohibited.
Passive	Prohibited.
8. Experimental Procedures	Prohibited except when death is inevitably devoid of them; employment must be under the supervision of experienced clinician.
9. Gene Therapy	Permitted to ameliorate serious disease.
10. Genetic Counseling	A right and is a proper exercise of man's knowledge to prevent tragedy.
11. In Vitro Fertilization "test tube" baby	Permitted.
12. In Vivo Fertilization	Permitted when couple is sterile; participation of surrogate mother must be devoid of coercion, with fully informed consent; all legal and social safeguards must be instituted.
13. Involuntary Commitment, Treatment	Permitted in the presence of even remote threat of life; in the presence of hope of return to a more normal state; least restrictive alternative to involuntary commitment and treatment should be employed.
14. Sterilization	Prohibited among males except when there is a threat of life.
15. Transplantation Surgery	Permitted provided that death of moribund donor is not thereby hastened; time of death should be determined by independent team of physicians; possibilities for long-term survival of recipient are significantly enhanced; permission of patient or next of kin must be obtained; sex organ transplantation permissible to correct infertility; cornea donation and transplant permissible; where patient's life is at stake, heart, kidney, liver, lung, pancreas, and colon transplants are permissible.
16. Trans-sexual Surgery	Prohibited.

formed in no small measure as a result of enhanced safety afforded by medical science. Jewish law generally prohibits abortion; the main exceptions being conditions involving a threat to the mother's life. The Talmud states, "If a woman is in hard travail and her life cannot otherwise be saved, one cuts up the child within her womb and extracts it, member by member, because her life comes before that of the child. But if the greater part of the head was delivered, one may not touch it, for one may not set aside one person's life for the sake of another."¹⁶

There is some dispute among Halachic scholars regarding the conditions under which abortion conceivably might be considered. The divisions generally are between authorities of the orthodox persuasion and those of the conservative and reform movements. None from among the first group would approve of terminating a pregnancy which occurred in less than

favorable conditions, e.g. poverty. Most orthodox rabbis would follow Israel's former Chief Rabbi Y.L. Unterman by permitting an abortion in the face of hysteria or genuine suicidal tendencies.¹⁷ Many conservative and most reform rabbis would concur with an abortion where there is a probability of severe physical deformity or profound retardation, such as is manifested in measles on the part of the child. For example, Rabbi Solomon B. Freehof, a leading exponent of the reform movement was asked the following question: "A young woman has contracted German measles in the third month of her pregnancy. Her doctor says that her sickness creates the possibility that the child, if born, may be deformed in body or mind. Some doctors, however, seem to doubt that this will happen. In other words, there are various opinions as to the probability of the child being born deformed. May she, according to Jewish law, have an abortion to terminate the pregnancy?"

To this the Rabbi replied, "I would . . . say that since there is strong preponderance of medical opinion that the child will be born imperfect physically or even mentally, then for the mother's sake, i.e., her mental anguish now and in the future, she may sacrifice this part of herself."¹⁸ The reform movement adopted a resolution in 1967 considering it religiously valid and humane for legislation that, "Recognizes the preservation of the mother's emotional health to be as important as her physical well-being; and properly considers the danger of anticipated physical or mental damage; and permits abortion in pregnancies resulting from sexual crime including rape, statutory rape, and incest."¹⁹ Conservative rabbis also are in agreement when pregnancies result from rape.²⁰

Eight years later the reform rabbinate reaffirmed its position, stressing furthermore that the decision to terminate or not terminate a pregnancy resides with the woman and her family. "We believe," wrote the members of the Committee, "that in any decision whether or not to terminate a pregnancy, the individual family or woman must weigh the tradition as they struggle to formulate their own religious and moral criteria to reach their own personal decision. We direct the attention of individuals and families involved in such decisions to the sentiments expressed in Jewish legal literature looking favorably on therapeutic abortion. We believe that the proper focus for formulating these religious and moral criteria and for making this decision must be individual family and not the state or other external body."²¹

Rabbi David M. Feldman, a noted conservative theologian has suggested the following modal Jewish position:

The principle that a mother's pain "comes first," however, is the most pervasive of all factors in the consideration of the abortion question. It produces the following fundamental generalization: if a possibility or probability exists that a child may be born defective and the mother would seek an abortion on grounds of pity for the child whose life will be less than normal, the rabbi would decline permission. Since we do not know for sure that he will be born defective and since we do not know how bad that defective life will be (in view of the availability of prosthetic devices, etc.), and since no permission exists in Jewish law to kill born defectives, permission on those grounds would be denied. If, however, an abortion for that same potentially deformed child were sought on the grounds that the possibility is causing severe anguish to the mother, permission would be granted. The fetus is unknown, future, potential, part of the secrets of God; the mother is known, present, alive, and asking for compassion.²²

TRIAGE

Almost synonymous with an economy of scarcity is the term triage, a system whereby individuals in need of care are prioritized in an effort to maximize the number of survivors. While there is some evidence in the Mishna of an acceptance of hierarchical schemes based upon social worth, the allocation of treatment based upon such plans generally is rejected. According-

ly, one eminent contemporary orthodox rabbinic authority, Rabbi Moses Feinstein ruled in an Israeli case involving several people in need of a limited supply of penicillin that it be disbursed on a first-need first-served basis. Significantly and consonant with the above, the obligation to treat extends only to those cases where there is any justifiable possibility of therapeutic efficacy.

Jewish law generally prohibits abortion; the main exception is a condition involving a threat to the mother's life.

Another level of triage exists when societal needs are pitted against those of the individual. A moment's reflection suggests that the obligations of society transcend the individual in at least two important respects. First, through the institution of government, society is charged with guaranteeing the safety of its constituent members. Second, only society can incur a debt on future generations while also possessing the resources necessary to help insure intergenerational welfare and safety. It follows from this that the individual might need to be sacrificed in a situation involving a threat to the larger community. Such thinking is reflected in the Israeli government's policy regarding hostages. To pay ransom, it is argued, would be to encourage a proliferation of terrorist activity, a clear threat to many. Israel, as a government, therefore never pays ransom. While the freeing of hostages is preeminently valued in Judaism, the approbation of such activity as pointed out by Rabbi Moses Tendler, fundamentally is limited to the level of the individual.²³

CONCLUSION

Jewish law is a living one in which its adherents regardless of denominational affiliation are exhorted to "live by them." This is taken to mean that it is considered highly desirable to ponder carefully the Halachic implications of what is *au courant* in any given era. Religious leaders from among the three denominations considered in the above discussion have established organizations to help address the relationship of the Halacha and medical practice. One such group in the orthodox fold can be contacted by writing the Office of the Secretary, Medical Ethics Committee, New York Federation of Jewish Philanthropies, 130 East 59th Street, New York, NY 10022. The conservative orientation may be secured by contacting the Office of the Secretary, Committee on Jewish Law and Standards, The Rabbinical Assembly, 3080 Broadway, New York, NY 10027. Information regarding the reform approach to our topic is available from the Office of the Secretary, Responsa Committee, Central Conference of American Rabbis, 21 East 40th Street, New York, NY 10016.

Information provided in the Table relates to specific medical interventions and practices and represents an Orthodox perspective.²⁴ It should be emphasized that every case is unique and that the appropriate clergy and medical personnel should be consulted.

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CASE REPORT: VOLVULUS OF THE GALLBLADDER

DANIEL C. BUDD, M.D., AND DAVID L. FINK, M.D., PATERSON*

Volvulus of the gallbladder, a rare pathological entity, should be considered in the etiology of what appears to be acute obstructive cholecystitis in the elderly. Prompt surgical management should include detorsion and cholecystectomy to minimize the sequelae of a gangrenous viscus.

Volvulus of the gallbladder was described in 1898 by Wendel.¹ Since then, approximately 300 cases have been reported. Volvulus of the gallbladder represents an acute surgical problem resulting in death unless cholecystectomy is performed promptly.

CASE REPORT

An 85-year-old female nursing home resident had a 24-hour history of continuous right side abdominal pain with nausea and vomiting. Upon hospitalization, her blood pressure was 154/100 mm/Hg, pulse 96, respirations 16/min, and temperature 100.2°F. Physical examination revealed maximal tenderness in the right upper and lower quadrants, diminished bowel sounds, and no mass.

Initial hemogram included: Hgb, 12.8 g; Hct, 42%; and WBC 6,000 with 76 segs, 5 bands, 10 lymphs, 9 monos. Urine analysis disclosed a small amount of ketonuria and 25 to 30 WBC/hpf. Liver function tests and amylase were normal. Serum electrolytes reflected a mild hypopotassinemia of 3.2 meq/L. Abdominal x-rays revealed a gas pattern consistent with an ileus. Ultrasonography of the gallbladder demonstrated multiple calculi without evidence of intra- or extrahepatic duct dilatation. A PIPIDA scan revealed no uptake in the gallbladder consistent with cystic duct obstruction. An upper gastrointestinal series was normal.

The presumptive diagnosis was acute cholecystitis and the patient was treated with parenteral cephalosporins, nasogastric decompression, and intravenous fluids. Within 48 hours, her temperature rose to 101.6°F and WBC to 14,600. We found marked right upper quadrant tenderness with guarding and rigidity. She was prepared for surgery. The gallbladder exhibited a 360° counterclockwise volvulus with complete gangrene extending down to the terminal half centimeter of the cystic duct (Figure). A single nonobstructing calculus was present within the gallbladder. The gallbladder was attached to the liver by a narrow mesentery at its neck, but otherwise was lying free. After derotation, cholecystectomy was performed with ease. The patient had an uncomplicated course and was discharged seven days later. Pathologic examination of the gallbladder showed diffuse ischemic infarction without perforation.

DISCUSSION

Torsion of the gallbladder has been reported in all age groups but the highest incidence has been noted in elderly women.² Most patients complain of acute

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Figure—Counterclockwise volvulus has resulted in complete gangrene of the gallbladder which is attached to the liver only by a narrow mesentery at its neck. Detorsion and cholecystectomy is the treatment.

onset of severe abdominal pain which may radiate to the back. Right upper quadrant tenderness is elicited, and in many cases a mass is palpable. The patients usually have a low-grade fever and mild leukocytosis. Although stones and inflammation probably are of secondary importance in the pathogenesis of this disease, it is of interest that gallstones occur in about half of the cases and that Wellsted noted a "square" gallbladder on ultrasonography.³ A DISIDA scan is positive confirming obstruction of the cystic duct not by calculus or inflammatory edema but simply by rotation of the gallbladder on its cystic duct axis.

Because of the difficulty of preoperative diagnosis, volvulus of the gallbladder must be considered in all patients with symptoms consistent with acute cholecystitis, especially if a mass is palpable in the right side of the abdomen. The correct preoperative diagnosis was made only once by Krabel in 1920.⁴ This was after an identical case the week before and was in turn followed by a missed diagnosis a year later.

Gross has defined two types of congenital anomalies of the gallbladder, occurring in 5 percent of the popu-

lation, which predispose to incomplete or complete torsion.⁵ In one type of anomaly, the gallbladder is surrounded completely by peritoneum, hangs freely in the peritoneal cavity, and is suspended only by a cystic duct mesentery. In the second, the gallbladder as well as the cystic duct have a well-defined but freely mobile mesentery. A third variant has been described only once by Rossouw in a Bantu woman wherein the gallbladder firmly was fixed except for a portion of the fundus which was unattached.⁶

Two types of gallbladder volvulus have been described. The first consists of a partial or incomplete torsion which involves a rotation of less than 180°, often has a gradual onset, with or without a palpable mass that may disappear after spontaneous detorsion. While the cystic duct becomes obstructed impeding bile flow, the circulation is not impaired. The second type consists of complete torsion, usually exceeding 180°, more often acute in onset with severe upper abdominal pain. Twisting of the cystic duct and vascular pedicle results in complete biliary obstruction with hemorrhagic infarction of the gallbladder. Signs of perforation, peritonitis, and shock may appear.

The cause of torsion has yet to be determined but peristaltic movements of the stomach and transverse colon have been implicated. It is possible that the sheer weight of a bile-filled gallbladder can cause a volvulus. Although some surgeons have treated this condition with suturing the gallbladder to the anterior abdominal wall or hepatic bed,⁷ the recommended treatment is cholecystectomy. Detorsion should be performed before cholecystectomy to prevent tenting and possible injury to the common duct.

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COMMENTARY: CAN THE ELDERLY AFFORD TO BE SICK?*

ANNE R. SOMERS, PRINCETON**

Health care expenditures for the elderly represent over half their average income. Current budget cutting plus basic deficiencies in Medicare and other programs signal trouble and the need for bold new approaches.

There is no simple "yes" or "no" answer to the question, "Can the elderly afford to be sick?" To the older person, the answer depends on income, family, and community support or the absence thereof, the nature of the illness or disability, adequacy of third-party protection, and the availability of alternative modalities of care.

INCOME

Despite improvement, income remains very low for most older people. In 1982, the median for all Americans over 65 was \$6,593.¹ For men, it was \$9,188; for women (who account for 60 percent of all over 65), it was \$5,365.² For both men and women over 70, the average income was only \$6,179. Similar figures are not available for those over 75 or over 85, but it is common knowledge that as we age, average income continues to fall steeply. It also is common knowledge that as we age, the proportion of women continues to rise so the "old old"—those over 85—are in double jeopardy with respect to income.

It also is easy to exaggerate the real improvement. For example, when price inflation is eliminated, the average 1982 income for men over 65, stated in 1967 dollars, was only \$3,180; for women, only \$1,860.³

The problem with family support continues to be very difficult. The family of the mid-1980s is very different from the traditional model. All the major de-

velopments—more working women, later marriage, more divorce, fewer children, greater geographic mobility, smaller and very expensive housing units, and fewer household employees—mean less available resources for direct family care. The size of the average family unit has declined dramatically, especially in the past decade. Seventy-seven percent of women over 75 are single: widowed, divorced, separated, or never married; 31 percent of men over 75 are single.⁴ Reflecting their marital status, 43 percent of older women and 17 percent of older men live alone or with nonrelatives.⁴ Sixty percent of those living alone rely on Social Security as their only income.

Despite recent progress in educational level, it remains surprisingly low. As late as 1979, about half of all older Americans had less than two years of high school.⁴ The relationship between education and income is well known.

About 5 percent of those over 65 are institutionalized. The rate rises from only 1 percent of those 65 to 70 to 10 percent of those over 75 and 22 percent of those over 85.⁵

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HEALTH STATUS

What about their health? Two-thirds of the elderly, like the majority of all ages, perceive their health to be excellent or good as compared to other people their age.⁶ This perception is important. It has been shown that self-perception of health is an excellent predictor of mortality during the succeeding decade.⁷ It also suggests the importance that should be attached to health maintenance or preventive medicine.

Their major health problems, as opposed to younger persons, are chronic—arthritis, hypertension, heart conditions, diabetes, stroke, cancer, dental disease, hearing, orthopedic and visual impairments, dementia, and mental illness. Among the reasons for the high rate of mental disorders: the isolation of many elderly individuals, loss or illness of spouse, and other chronic health conditions.

Despite numerous problems, over half of the noninstitutionalized elderly say they are not limited in activity.⁶ However, about 12 percent do need the help of another person in one or more activities of daily living. This figure rises to nearly 40 percent of those over 85. Perhaps the most surprising and memorable single statistic that I have encountered recently in this area is the fact that, despite frequent allegations of overuse or misuse of health care by the elderly, 42 percent of the Medicare-enrolled population received no reimbursements in 1979⁸ and 36 percent received none in 1982⁹—an eloquent tribute to the physical and mental health and financial responsibility of most of our elderly.

MEDICAL EXPENSES

What about medical expenses? The figures appear disproportionate to the relatively good health of the average elderly person. The Health Care Financing Administration estimates the 1984 average per capita expenditures for the over 65 at \$4,200.¹⁰ This is about three times the average for younger persons. Of this \$4,200, 45 percent (\$1,900) went for hospital care and about 21 percent each for physicians and nursing homes. Since income figures are not available for 1984, we cannot relate this \$4,200 figure to 1984 income. But with an average income less than \$6,600 in 1982 and with a rise in health care expenditures that substantially has exceeded the rise in personal income in every recent year, average health care expenditures for the elderly now represent over half of their average income.* Keep in mind that these are not theoretical figures as to what it would cost if the elderly had all the health care they or their physicians or families think they need, this is what actually is being spent today.

How do the elderly pay for health care? The answer is obvious: third-party payment—especially public programs. Public financing plays a much greater role in health care for the elderly than for the rest of the population. The latest study of this matter, by HCFA, reports that over two-thirds of all 1984 personal health care expenditures for the elderly were financed

through public sources: Medicare, Medicaid, and the VA.¹⁰ An additional 8 percent was paid through private health insurance or philanthropy, leaving 25 percent for direct patient payment.

While the elderly and their physicians have to be deeply grateful to Medicare, Medicaid, and other third-party programs for helping to ease the burden of these medical costs, there also are grounds for real concern. Even before the budget-cutting of the past few years, there were serious deficiencies in the financing programs. Chronic care, the inevitable consequence of progress in acute care, always has been neglected in both Medicare and private insurance. The result is that some three to four million older Americans, suffering from stroke, heart disease, severe arthritis, cancer, Alzheimer's disease, and other mental and neurological illness clearly cannot afford the health care they need. While long-term care is provided under Medicaid and the VA, eligibility generally is limited to the very poor leaving the middle-class long-term care patient totally out in the cold.

Preventive services also are specifically banned under Medicare and most private insurance policies. The stupidity of this penny-wise, pound-foolish benefit policy becomes more evident every day as new studies report the effectiveness of prevention in postponing or mitigating the consequences of high blood pressure, heart disease, osteoporosis, diabetes, cancer, glaucoma, and other serious chronic diseases.

On top of these long-standing deficiencies, there is a major drive to cut Medicare, as well as Medicaid, costs. One cannot quarrel with the need for cost containment. Medicare's revenues are falling seriously behind expenditures, which for several years were rising at about 17 percent a year,⁹ and the Part A Hospital Trust Fund is expected to be exhausted in a decade. Even if adequate additional revenues could be found, it is morally and politically unacceptable to continue the original Medicare blank-check reimbursement provisions in a world where millions of human beings are literally starving to death and probably 75 percent of the world's population have grossly inadequate health care.

But that does not mean endorsing every suggestion for cutting costs. On the contrary, one must question many of the specific proposals as well as the generally cavalier attitude with which many approach the so-called Medicare problem.

Without question, Medicare is faced with a real financial crisis. Lack of adequate financial controls is one, but only one, cause of that crisis. The aging of the population, progress in medical science which, paradoxically, results in more—not less—long-term illness and disability, the absence of cost-effective programs for the care of such long-term patients, and the expensive pro-technology bias in the Medicare program today are all parts of the problem. The crisis will not be solved by ill-considered, unidimensional approaches.

Can the elderly afford to be sick? The answer is no. With current expenditures averaging over half of median income, clearly most of us currently are being subsidized heavily by the taxes of the younger population. Perhaps this is as it should be, replacing for many younger people the financial responsibilities

*It may be objected that I am comparing mean expenditures with median income. Mean income would be somewhat higher. However, I have allowed for this in my estimate of "over half."

they formerly bore with respect to their own parents or other elderly relatives. Indeed, such spreading of risk and cost—across the generations and across broad population groups—is one of the major purposes of health insurance.

But there are several catches in this comforting argument: 1) As already noted, most current financing programs fail to cover long-term care, the biggest single health-care burden facing older people today; 2) The demographic and technologic imperatives influencing the future (demand, supply, and price of health care) imply a virtually unending rise in costs; 3) There are signs of increasing resistance to this burden on the part of employers, younger taxpayers, and younger employees. The surprisingly conservative vote of the majority of young Americans in the last election reflects this rising resistance.

CONCLUSION

Perhaps the most encouraging aspect of the current scene is the rapid growth of professional interest in geriatrics, in the changing health needs of the elderly and in the need to adjust our health care institutions to meet the changing needs. If the current inadequacies of health care for the elderly are not to be made worse, rather than better, by changing national poli-

cies, it will require the work of many people.

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CURRENT NUTRITION: FOCUS ON OBESITY IN ADOLESCENTS*

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The nutrition of the adolescent is complicated by the requirement for physical maturation and the vacillating influences of psychosocial development. Together, obesity and its treatment are a fitting paradigm.

Inquiries about nutrition are among the most frequent questions encountered by the physician in adolescent practice: How do I lose weight? How do I gain weight? What foods shall I eat? What foods should I avoid? Shall I take vitamins? How can I improve my appetite? Unfortunately, accurate advice often is dependent on so many variables that the health professional is hard pressed to develop appropriate answers. Present health status, sex, age, energy demands, and climatal environment all affect the nutritional equation. In addition, nutritional counseling for the adolescent further is complicated by the demands of pubertal maturation and psychosocial development.

PUBERTAL MATURATION

Puberty is a period of rapid growth and maturation during which the adolescent undergoes the metamorphosis that transforms the juvenile body into an adult body. Gains in body size eventually will account for 10 to 15 percent of the final adult height and almost 50 percent of the eventual adult weight.¹

This metamorphosis also heralds the phenotypic expression of the endocrinological difference in the sexes. At the beginning of their respective puberties, there is no significant difference in the average height and weight of American males and females.¹ At age ten, the average male is 140 cm, the average female 138 cm;

the average male weighs 32.6 kg, the female weighs 31.8 kg. During puberty the average male gains 24 cm in height and 30.4 kg in weight; the average female adds 24 cm in height and 22.2 kg in weight.¹ In addition, body composition also has different sexual expressions. Both the male and the female adolescent experience an absolute increase in lean body mass; however, this gain is more prominent in the male, especially in the limbs and shoulder girdle. In the male, there is a loss of subcutaneous fat; in the female, there is a redistribution in subcutaneous fat as well as a gain in the total mass of adipose tissue.¹

Finally, the maturational process further is complicated by the physiological rather than the chronological timing of the events. Each adolescent has his own biological time clock. Some will begin puberty at 8 or 9, others will wait until 15 or 16.¹ The adolescent's individual energy demands for growth are predicated on their physiologic timing.

*This column is prepared under the direction of Herman Baker, Ph.D., Professor, Preventive Medicine/Community Health and Medicine, UMDNJ-New Jersey Medical School.

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PSYCHOSOCIAL DEVELOPMENT

Of no less importance to the nutritional equation is the adolescent's psychosocial development. The teenager evolves through the stages of early, mid, and late adolescence on the way to adulthood. During this transition, the teenager moves from a period where he responds to parental authority—although grudgingly—in early adolescence, to mid-adolescence where peer identification is an essential component of life; to late adolescence where decision making is his own. In early adolescence, nutritional decisions are related closely to parents; in mid-adolescence, these decisions are influenced by peers and respected role models; in late adolescence, these decisions are the result of independent evaluation. Effective nutritional counseling requires modifications which respond to the adolescent's maturational stage.

Few adolescent nutritional disorders are as prevalent and as distressing as obesity. In this article, we will focus on the pathophysiology of teenage obesity and outline a therapeutic approach that has been successful in our clinical practice.

OBESEITY

Obesity is the most common nutritional health problem among adolescents in developed countries. Conservative estimates place the rate of American teenage obesity at 16 to 25 percent.³⁻⁶ An estimated 30 percent of the adult male and 40 percent of the adult female population of the United States are obese. In addition, many other adolescents who are not obese are actively struggling to keep their weight within the "lean and trim" range that is idolized by our society.

Although there is little morbidity or mortality attributable to obesity during the adolescent years, it is a health liability for the teenager because of its tendency to affect adversely psychosocial development and long-term health status. Without remediation, more than 80 percent of overweight children will become overweight adults.^{5,9} An obese 12 year old has less than a 25 percent chance of having a normal weight as an adult; and if the weight loss is not accomplished by the end of adolescence, the chances fall to less than 4 percent.¹⁰

The tendency for obese children to remain obese has great significance prognostically because it links childhood obesity to some of the most serious disorders of adult life—hypertension, diabetes, and coronary heart disease. In addition, during childhood and adolescence, obesity appears to be related to decreased growth hormone release, hyperinsulinemia, carbohydrate intolerance, hypertension, and hyperlipidemia.¹¹⁻¹⁴

The emotional and social consequences of obesity often are devastating. Overweight adolescents are the targets of peer disapproval and abuse. They frequently complain of disturbed family interactions,¹⁵ and they have a higher incidence of personality disorders.¹⁶ Obese high school students suffer academic discrimination and they experience a lower rate of admission to college than equally qualified students of normal weight.¹⁷

Poor self-image tends to be the most severe psychological consequence of teenage obesity.¹⁸ The sense of worthlessness produces a perpetuating spiral of con-

tinual feelings of rejection, withdrawal, isolation, depression, boredom, and inactivity that results in increased eating and maintenance of excess body fat.

Obesity is the result of a multifactorial complex of metabolic, genetic, neurochemical, sociocultural, and psychosocial phenomena. In childhood, the process is most likely to begin between under four years and seven and ten years of age.¹⁹ Hirsch et al. have demonstrated an increase in fat cell size (hypertrophy) and number (hyperplasia) with increasing age during infancy and childhood.²⁰ Maximum values are reached in adolescence and young adulthood. After maturation, the fat cell number cannot be altered. Overfeeding during infancy and early childhood will result in an increase in the number of fat cells (hypercellularity). Overeating later in childhood and adolescence will increase the size of fat cells (hypertrophy) but the number will remain unchanged. Similarly, weight reduction efforts during adolescence will decrease the fat cell size but not affect the hypercellularity of fat tissue. Therefore, weight stabilization and reduction programs should begin as early as possible to minimize the hypercellularity of the body fat mass.

Obesity offers the greatest challenge and frustration for patient and clinician.

The contribution of overeating to obesity is obvious; however, the motivation for an individual's excessive overeating seldom is understood. Often the hyperingestion of food is attributed to the psychosocial problems that are ubiquitous in the obese adolescent. However, it often is difficult to determine whether the obesity causes the emotional problems or whether emotional problems cause obesity. Regardless of which comes first, obese teens obtain satisfaction from eating instead of more typical sources of gratification, i.e., sports, dating.

An early decrease in caloric requirements is an important etiologic factor in the adolescent female. Today most girls have their adolescent growth spurt between 10 and 11 years of age and menarche at 12. After menarche there is a minimal increase in linear growth and lean body mass, but a continued rise in body fat.^{21,22} This change in growth rate is accompanied by a significant drop in energy requirements (from 2,600 cal/day before menarche to 2,000 cal/day after menarche). In addition, a previously active girl may decrease her physical activity because of self-consciousness about her developing body thereby further decreasing her caloric requirement. However, if she does not also decrease her caloric intake she will gain weight.

Traditional approaches to the control of obesity in adults have been plagued by high dropout rates, limited weight loss, and high recidivism. Studies of the treatment of childhood obesity have shown equally disappointing results. Long-term treatment is successful in only 5 to 20 percent of patients.²³ In predicting the prognosis for a particular teen, the clinician should consider the etiology of the obesity, age of onset, dur-

ation, family, social and psychological factors, and medical risk. In some individuals, the chances for success are so remote that it may be better to assist them in controlling eating behavior and stabilizing weight rather than subjecting them to the failure of dieting.

The limited effectiveness of traditional treatments for obesity has produced a favorable climate for the introduction of new measures and new modalities. The most successful weight reduction program for teens consists of a multifaceted program which includes: behavior modification, nutritional counseling, and exercise. In combination these modalities have been shown to produce the best results in both adults and children.²⁴⁻²⁶ One of the major shortcomings in other approaches is that they rely on treatment strategies that focus on only one aspect of the problem. Since the etiology of obesity is multifactorial the approach to treatment should encompass all the many and varied contributants. Behavior modification is designed to recognize and alter an abnormal eating pattern. Conceptually, these abnormal patterns are learned coping responses that occur within a complex social and cognitive environment. Once they are recognized the maladaptive learned responses systematically can be unlearned and new adaptive patterns can be incorporated.

A careful behavioral analysis of specific eating behaviors is an integral part of the behavioral modification treatment program. An analysis of the antecedents to eating can determine the stimuli that may have initiated the aberrant eating behavior. Similar analysis of the consequences can reveal the rewards or punishments that serve to increase or decrease the overeating (or other poor nutritional habits). Behavioral programs attempt to alter the antecedent stimuli, to control the act of eating itself, and to reinforce these behavioral changes.

Positive reinforcement increases the likelihood that a desired behavior will reoccur. Therefore, a system of formal rewards constitutes an essential component of all programs. Generally, it is more effective to establish separate reward systems for changes in behavior and for weight loss.

Nutritional education also is important in a total program of weight control. Teaching the adolescent nutritional principles will give the teen the capabilities to maintain weight loss in the future without compromising needed protein and nutrients.

Physical exercise and activity is another mainstay of a total program. Obese adolescents generally are physically inactive; even in the performance of athletic activity they move significantly less than their lean peers.²⁶ An exercise program would help these patients by utilizing calories and improve cardiovascular status.

Obesity is the number one nutritional problem in adolescents and should receive as much effort as possible in research of new and useful treatment modalities.

Of all nutritional ills, obesity offers both the greatest challenge and the greatest frustration for both the patient and the clinician. This dilemma particularly is

problematic for the adolescent who adds in the complexities of growth and development. Nevertheless, the consequences and the mere possibility of remediation warrant our judicious intervention.

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9:00 A.M.-4:30 P.M.

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9:00-9:15	Introduction
9:15-10:00	Search for the Right Opportunity • How the Changing Complexion of Health Care Will Affect You • Professional Consideration in Selecting a Site • Personal Considerations • Financial Considerations
10:00-10:15	Questions and Answers
10:15-11:15	Types of Practice • Solo • Partnership • Group • HMOs
11:15-11:30	Questions and Answers
11:30-12:00	Physical Facilities • Space Requirements • Floor Plans • Patient and Work Flow
12:00-12:15	Questions and Answers
12:15-1:00	Lunch

AFTERNOON PROGRAM

1:00-1:30	Business Insurance • Types • How Much and When
1:30-1:45	Questions and Answers
1:45-2:30	Personnel • What You Need • How to Find • Job Descriptions • Performance Reviews and Salary Reviews
2:30-2:45	Questions and Answers
2:45-3:15	Systems • Time Management • Charts and Records • Phones • Billing, Insurance and Collection • Fees • Medicare
3:15-3:30	Questions and Answers
3:30-4:15	Financial Management
4:15-4:30	Questions and Answers
4:30	Adjournment

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Department of Professional
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Medical Inter-Insurance
Exchange of New Jersey
Department of Risk Prevention

8:30- 9:00 **Registration**

9:00-11:15 **General Session**

Opening Remarks

*James E. George, M.D., J.D.
Director, Department of
Professional Liability Control*

Greetings

*Ralph J. Fioretti, M.D., President
Medical Society of New Jersey
and
Peter Sweetland, President
Medical Inter-Insurance Exchange
of New Jersey*

**AMA Response to a
National Crisis**

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of Directors of the Washington, DC
physician-owned insurance carrier,
Chairman AMA's Committee on
Professional Liability*

**A Report on NJ Department of
Insurance Task Force on
Professional Liability**

*Commissioner Hazel Gluck
Commissioner of the New Jersey
Department of Insurance*

**Tort Reform—
A Legislative Update**

*Robert S. Maurer, D.O., Chairman
Legislative Committee, Medical
Inter-Insurance Exchange of New Jersey*

11:15-12:00 **Question and Answer Period**

12:00-12:30 **Lunch**

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UMDNJ Notes; AMNJ Report; Annual Medico-Legal Seminar; New Members; Physicians Seeking Location in New Jersey

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

When Dr. David Goldenberg came to UMDNJ from the University of Kentucky two years ago to form a private-public high technology research partnership, we believed his Center for Molecular Medicine and Immunology (CMMI) would be a leader in the field of cancer diagnosis and treatment. Since coming to our Newark campus, Dr. Goldenberg has certainly met our expectations. The significance of his work was underscored when he was honored with a \$9.7 million Outstanding Investigator Award from the National Cancer Institute (NCI). Dr. Goldenberg was one of only 18 researchers in the country to receive the prestigious award, and the only one recognized for research in the area of cancer diagnosis. Governor Thomas H. Kean presented the award during ceremonies at CMMI headquarters on our Newark campus.

Dr. Goldenberg noted that the grant will fund research with monoclonal antibodies that hone in on tumor cells. Under the researcher's direction, CMMI has developed anti-

bodies that are drawn to antigens on the surface of tumor cells. The antibodies are marked with diagnostic isotopes and injected into the body, where they zero in on the cancerous site, to be detected by diagnostic scanning equipment. This radio-immunodetection method is locating cancers much earlier than traditional diagnostic procedures and, in some cases, confirming tumors that have gone undetected through conventional means.

Dr. Goldenberg said the NCI grant also will strengthen further research in developing more selective antibodies to provide diagnosis of several kinds of cancer. He hopes the research will lead to diagnosing very small tumors, and simplifying the procedure so that it can be performed in any hospital.

In addition to its diagnostic features, CMMI is investigating the use of these antibodies as "magic bullets," whereby a strong dose of radiation or anti-cancer medication is delivered to the cancerous site without harming normal, healthy tissue.

Sammy Davis Jr. Liver Institute.

Several months ago at a press conference on UMDNJ's Newark campus, world-renowned entertainer Sammy Davis, Jr., vowed to invest "whatever is necessary" in order to make the Liver Institute bearing his name a success. True to his word, Mr. Davis has given of himself since we announced the establishment of the Sammy Davis, Jr. National Liver Institute in June. The singer-actor-comedian recently returned to the University to gain firsthand knowledge of the research currently underway at the UMDNJ-New Jersey Medical School aimed at combating liver disorders. He spent an entire day in discussion with Dr. Carroll Leevy, professor and chairman of medicine and the scientific director and acting board chairman of the Institute, as well as with other department chairmen who together offered Mr. Davis a multidisciplinary picture of the liver research underway on our campus and how it all will come together under the auspices of the center.

In addition, I am happy to announce that we are on target for the Institute's inaugural dinner. The black tie event is set for Monday, October 28 at the Loew's Glenpointe Hotel in Teaneck. The master of cer-

emonies is actor-comedian Bill Cosby. Arthur E. Imperatore, chairman of A.P.A. Transport, is the dinner chairman.

The evening will begin with a cocktail reception at 6:30, followed by dinner at 7:30. Mr. Davis will honor the gathering with a performance at 9. Tickets are \$300 per person, \$3,000 for a table of ten. A table of ten for \$5,000 entitles guests to priority seating and a Sammy Davis Jr. commemorative. If you're interested in attending the dinner, further information can be obtained by contacting Eileen Lentz, dinner coordinator, (201) 762-2766.

AMNJ Report

Dennis R. Filippone, M.D.
President

In late August, the Academy of Medicine mailed its popular Annual Calendar for 1985-1986 to all Fellows and Institutional Members throughout New Jersey. Receipt of this publication always is a signal that the academic year is about to begin and it is obvious from the impressive content that this will be our most prolific year ever.

On September 18, our Education Committee under the chairmanship of Dr. Alfred Alessi, held their annual joint meeting with our scientific section officers. The purpose of the meeting was to orient the new committee members and section officers to their role in the Category I accreditation process and the mechanism to schedule section scientific meetings. Over 30 committee members, section officers, and staff attended.

On Thursday, October 17, 1985, Dr. Alessi and Mr. Cal Heitzmann will represent the Academy in Chicago for our accreditation resurvey by the Accreditation Council for Continuing Medical Education (ACCME). A lengthy application was completed by staff over the summer and submitted in early September.

The Academy in cooperation with the Newark Beth Israel Medical Center will hold our first Major Symposium of the academic year on Thursday, October 10, 1985. The program, "A Symposium on Controversies in Cardiology," will be held at the Danzis Auditorium of the Newark Beth Israel Medical Center in Newark. The Symposium is designed to acquaint internists,

cardiologists, and interested primary care practitioners with contemporary clinical, therapeutic, and laboratory modalities. At the completion of the program we expect participants: to discuss six areas of clinical controversy recalling the most current concepts of cardiac patient management; to compare therapeutic approaches based on discussion of controversies; and to recall both positive and negative aspects of selected diagnostic and therapeutic approaches.

The topic for the Academy's first First Wednesday program of the year was "PRO—Its Present Impact and Future Implications." This subject, of major current interest to New Jersey physicians, was presented by Dr. Joseph A. Lieberman, III and Dr. D.D. Griffith. Dr. Lieberman is a member of the Board of PRO of New Jersey,

Central Division and Dr. Griffith is their medical director. Dr. Lieberman also is chairman of the department of family medicine at UMDNJ-Rutgers Medical School and a newly elected trustee of AMNJ.

Annual Medico-Legal Seminar

Raymond Scalettar, M.D., Member, Board of Trustees of the American Medical Association, Ms. Hazel Gluck, Commissioner of Insurance, and Robert Maurer, D.O., will be the principal speakers at the Sixth Annual Medico-Legal Seminar.

Raymond Scalettar, M.D., an internist and rheumatologist from Washington, D.C., was elected to the AMA Board of Trustees in June 1985. Doctor Scalettar's topic of dis-

cussion at the seminar will be on the national malpractice crisis. The title of his topic is "AMA Response to a National Crisis."

Hazel Frank Gluck was appointed Commissioner of Insurance by Governor Kean and was sworn into office on March 11, 1985. An insurance commissioner, she oversees an \$11 billion insurance industry and an \$8.4 billion real estate industry. Physicians who attend the seminar will be able to hear Commissioner Gluck speak on the topic of the "New Jersey Department of Insurance Task Force on Professional Liability."

Robert Maurer, D.O., is chairman of the legislative council of the Medical Inter-Insurance Exchange of New Jersey. Dr. Maurer's topic will be: "Tort Reform—A Legislative Update."

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Programs may be taped for alternate viewing times.

New Members

The Medical Society of New Jersey would like to welcome the following new members:

Atlantic County

Kian K. Chong, M.D., Pomona
Andrew Renny, M.D., Northfield

Bergen County

Raghu V. Ballal, M.D., Paramus
Peter W. Coppola, M.D., Teaneck
Jose A. Longo-Salvador, M.D.,
Cliffside Park

Francis J. Piccione, D.O., Hawthorne
Benzion Sacolick, M.D., Fort Lee
Michael J. Torsiello, M.D., Ridgewood

Burlington County

Marc F. Goldstein, M.D., Cherry Hill
Michael J. Neary, M.D., Medford
Leon I. Rosenberg, M.D., Moorestown

Camden County

Gerald V. Burke, M.D., Haddonfield
Steven Davidoff, M.D., Haddonfield
Alfred L. Harkley, M.D., Voorhees
Jay M. Malamut, M.D., Cherry Hill
Keith F. O'Malley, M.D., Camden
Alan N. Miller, M.D., Camden
Igor G. Rayevsky, M.D., Collingswood
Jon Marshall Regis, M.D., Marlton
Steven E. Ross, M.D., Camden
C. William Schwab, M.D., Camden
Mark A. Sobel, M.D., New York, NY
Raymond C. Talucci, M.D., Camden
James W. Vick, M.D., Haddonfield
Howard S. Waxman, M.D., Medford

Cumberland County

Matthew J. Soff, M.D., Bridgeton

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Stephan A. Billstein, M.D., Nutley
Matthew J. DeLuca, M.D., Glen Ridge
Maximo C. Napuli, M.D., Newark
Mary Natrella, M.D., South Orange

Hudson County

Imad Y. Baghal, M.D., Jersey City
Angelo A. Caprio, M.D., Secaucus
Claudio F. D'Alberti, M.D., Hoboken

Bhushan H. Pandya, M.D., Bloomfield
Esmat S. Sharobeem, M.D.,
Staten Island, NY

Hunterdon County

Mary Alma Hine, M.D., Flemington

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Albert Y. Choe, M.D., Trenton
Abraham George, M.D., Trenton
Kay C. Kerr, M.D., Trenton

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New Brunswick
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Ronald M. Selby, M.D., New Brunswick
Edgardo L. Tan, M.D., Elizabeth

Monmouth County

Frank Craparo, M.D., Lincroft
Jocelyn L. Craparo, M.D., Lincroft
Paul J. Gilson, M.D., Neptune City
Donald A. MacDonald, M.D., Leonardo
Ellis David Morgan, M.D., Neptune
Roger M. Thompson, M.D., Middletown

Morris County

Evamarie U. Eskin, M.D., Madison
John A. Jacobey, III, M.D., Dover

Ocean County

Thomas L. Barnes, M.D., Manahawkin
Robert J. Gialanella, M.D., Toms River
Lawrence J. Grill, M.D., Lakewood
William Y.C. Hong, M.D., Manahawkin
Neil H. Robinson, M.D., Toms River
Steven Sobo, M.D., Toms River

Passaic County

Vibhakar K. Baxi, M.D., West Paterson
Dan T. Bernheim, M.D., Clifton
John A. Colaneri, M.D., Carlstadt
Jo-Ann Szyllit, M.D., Wayne

Somerset County

Elizabeth A. Balint, M.D., Somerville

Sussex County

Donald H. DeLong, II, M.D., Newton

Union County

Harvey M. Binder, M.D., Summit

Janak Sarkaria, M.D., Fords
Paul M. Schlosser, M.D., Summit
Aloma P. Sevilla, M.D., Cranford
Arthur S. Verdesca, M.D., Berkeley
David E. Wexler, M.D., Rahway

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—David J. Valacer, M.D., 42 Wachusett Ave., Shrewsbury, MA 01545. University of Vermont 1975. Also, immunology. Board eligible. Board certified (P). Group, partnership, solo. Available.

CARDIOLOGY—David A. Gehring, M.D., P.O. Box 5610, Hobbs, NM 88241. University of Pittsburgh 1956. Also, internal medicine. Board eligible. Board certified (IM). Group or partnership. Available.

M.A. Mottaghian, M.D., 118 Vernal St., Everett, MA 02149. Isfahan Medical (Iran) 1965. Board eligible. Also, internal medicine. Full- or part-time practice. Available.

DERMATOLOGY—Steven Fenichel, M.D., 337 S. Harvey, Oak Park, IL 60302. Royal College of Surgeons (Ireland) 1976. Board certified. Solo, partnership, group. Available.

GENERAL PRACTICE—Susan F. Stickels, M.D., 1913 E. Kenmore Pl., Shorewood, WI 53211. Board certified. Group or HMO. Available.

IMMUNOLOGY—David J. Valacer, M.D., 42 Wachusett Ave., Shrewsbury, MA 01545. University of Vermont 1975. Also, allergy. Board eligible. Board certified (P). Group, partnership, solo. Available.

INTERNAL MEDICINE—Tsodil Aronin, M.D., 1945 Ocean Ave., Apt. 6, Brooklyn, NY 11230. Vitebsk Medical Institute (USSR) 1954. General practice, group, clinic, hospital. Available.

Neil H. Caplan, M.D., 27 W. Penn St., Long Beach, NY 11561. Bowman Gray. Board eligible. Outpatient or clinic setting. Available.

David A. Gehring, M.D., P.O. Box 5610, Hobbs, NM 88241. University of Pittsburgh 1956. Also, cardiology. Board certified. Board eligible (CARD). Group or partnership. Available.

Eli R. Goldner, M.D., 2841 W. Rosemont, Chicago, IL 60659. University of Rome (Italy) 1980. Board eligible. Partnership or group. Available February 1986.

ARE YOU MOVING?

If so, please send a change of address to **NEW JERSEY MEDICINE**, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

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Frederic M. Heitzer, M.D., 3rd Ave., 160B Borden Apts., Long Branch, NJ 07740. UMDNJ 1982. Group, partnership, clinic, industry. Available.

Nancy Hoffman-Wadhwa, M.D., One Maidstone Ct., Apt. M, Baltimore, MD 21237. St. George University (Grenada) 1982. Board eligible. Available.

M.A. Mottaghian, M.D., 118 Vernal St., Everett, MA 02149. Isfahan Medical (Iran) 1965. Board eligible. Also, cardiology. Full- or part-time practice. Available.

Robert E. Sunenblick, M.D., 3355 Queen Mary Rd., #427, Montreal, Quebec, Canada H3V 1A5. Hahneemann 1974. Solo, group, partnership, HMO. Available.

Viswanath P. Vasudevan, M.D., 102-12 65th Ave., Apt. D-64, Forest Hills, NY 11375. University of Bombay 1976. Also, pulmonary. Board certified. Solo or group. Available.

Dom Wadhwa, M.D., One Maidstone Ct., Apt. M, Baltimore, MD 21237. St. George University (Grenada) 1982. Board eligible. Available.

OCCUPATIONAL MEDICINE—Alexander A. Boytar, M.D., 493 Creek Rd. Ext., Lewiston, NY 14092. Budapest 1948. Group, salaried, industrial. Available.

PEDIATRICS—Patrick A. Caruso, M.D., 157 Goodwin St., Bristol, CT 06010. Case Western Reserve 1983. Board eligible. Group or HMO. Available.

Édgar Lyubling, M.D., 1401 Ocean Ave., Apt. 4H, Brooklyn, NY 11230. Moscow (USSR) 1967. Group or partnership. Available.

Boroumand Masood, M.D., 85-26 Van Wyck Expwy., Apt. 412, Briarwood, NY 11435. Tehran (Iran) 1968. Board certified. Group, partnership, solo, hospital. Available.

Pronoti Nigam, M.D., 24 Hart Blvd., Flemington, NJ 08822. Kanpur (India). Board eligible. Group or partnership. Available.

Vito A. Petrozzino, M.D., 1201 West McGaffey, #39, Roswell, NM 88201. Guadalajara (Mexico) 1976. Board eligible. Group or partnership. Available.

PULMONARY—Thomandram S. Sekar, M.D., 1420 Deerbrook Ct., Bluffton, IN 46714. Stanley Medical College 1970. Board certified. Group, partnership, solo, hospital. Available.

Viswanath P. Vasudevan, M.D., 102-12 65th Ave., Apt. D-64, Forest Hills, NY 11375. University of Bombay 1976. Also, internal medicine. Board certified. Solo or group. Available.

SURGERY—M. Farrukh Ali Khan, M.D., 785 Oak Ridge Dr., P.O. Box AF, Lisbon, ND 58054. B.S. King Edward Medical College (Pakistan) 1975. Available.

Anthony J. Menichino, M.D., 82 Niagara Falls Blvd., Buffalo, NY 14214. Guadalajara (Mexico) 1973. Board eligible. Group, partnership, solo. Available.

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PEDIATRIC UPDATE 1986

Camino Real, Cancun, Mexico

February 11-16, 1986

Sponsored by: Department of Pediatrics, Schneider Children's Hospital, Long Island Jewish Medical Center, New Hyde Park, NY. Faculty: Philip Lanzkowsky, M.D., William W. Cleveland, M.D., Wm. E. Hathaway, M.D., and Henry R. Shinefield, M.D. Credits: 21 hours Category 1 ACCME, AMA and AAFP. Information: Continuing Education Coordinator, Long Island Jewish Medical Center, New Hyde Park, NY 11042, (718) 470-8650.

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 50-hour accredited seminar and workshop on the latest theories & techniques of manual & electro-acupuncture and TENS, applicable toward the 200-hour requirement for certification, will be given for licensed clinicians (with or without prior training). First International Symposium on Acupuncture & Electro-Therapeutics at New York Pental Hotel, Oct. 9-13, 1985. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its official journal, *Acupuncture & Electro-Therap. Res., Int.J.* (published by Pergamon Press and Indexed in 15 major indexing periodicals; INDEX MEDICUS, etc.), American Museum of Natural History, the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital, Pharmacology Dept. of The Chicago Medical School. Also eligible for AMA/CME credit. For information, contact Y. Omura, M.D., ScD., 800 Riverside Drive (8-1), NYC 10032. Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.



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CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE
CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

WEDNESDAY, NOVEMBER 6, 1985

PHYSIOLOGIC PACEMAKERS

MODERATOR: GARY J. ANDERSON, M.D.

- | | | |
|------|--|---------------------------------|
| 3:00 | CASE PRESENTATION: BRADYARRHYTHMIAS | <i>Theodore J. Waller, M.D.</i> |
| 3:30 | DISCUSSION, INCLUDING INDICATIONS FOR PACING | <i>Allan M. Greenspan, M.D.</i> |
| 4:00 | CASE PRESENTATION: PACEMAKER SYNDROME | <i>Theodore J. Waller, M.D.</i> |
| 4:30 | DISCUSSION, INCLUDING PATHOPHYSIOLOGY AND RESULTS
OF PHYSIOLOGIC PACING | <i>Steven P. Kutalek, M.D.</i> |
| 5:00 | QUESTIONS AND ANSWERS | <i>The Audience</i> |

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LETTERS TO THE EDITOR

Preadmission Certification

July 26, 1985

Dear Doctor Krosnick:

As you are well aware, any medi-

cation, treatment, therapy, program of patient management, or administrative procedure either can be beneficial or a deterrent to the best interests of any particular patient at any given point in time. Appropriate treatment of the patient and effective management of his illness must continue as our primary concern.

Resolution #14 relates to preadmission certification. The whereases refer to Title XVII but the resolveds are general—all are inherently derogatory. I believe that there are beneficial aspects as well as potential dangers of misuse: In the patient's best interest—Elective admissions. a) appropriate setting; Conscious evaluation by the physician of OP, SDS, or admission. b) Identification of need for second opinion. c) Early discharge planning with all its ramifications. d) Identification to physician of alternate sites or special forms of therapy available. e) Early opportunity for special arrangements such as transportation, transfers to tertiary care, rehabilitation centers, consultation, or S.N.F. f) Identifi-

cation of covered versus not-covered benefits.

Although denial may be by nurses in some systems, it should be noted that in our IPA-HMO system, the nurse coordinator cannot deny an admission, only the medical director has this authority—but to my knowledge it has never been exercised although alternate approaches have been suggested to, and accepted by, the requesting physicians.

Finally, there is an opportunity to inform the physician of the almost limitless services on an ambulatory basis where medically necessary.

I also would agree that subscribers should be informed of this benefit requirement.

The times they are a-changing and it is imperative that clinicians increase their involvement in evaluating and monitoring all scientific-management-fiscal policies and procedures that affect our patients.

(signed) Henry J. Mineur, M.D.
Medical Director, CJIPA

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**Carpal Tunnel Syndrome;
Clinical Consultations of
Giovanni Morgagni;
Symptoms and Signs in
Cardiology; Physician's
Handbook**

Carpal Tunnel Syndrome

W. Bruce Connolly, M.D. Oradell, NJ, *Medical Economics*, 1985. Pp. 96. Illustrated. (\$25.95)

This monograph was written by W. Bruce Connolly, the hand surgeon at Sydney Hospital, Sydney, Australia. The book is written and arranged in a useful and concise fashion; the color pictures are of good quality.

The diagrams and tables in the historical section are all well-structured and some of the pictures of unusual cases of carpal tunnel syndrome are unique.

The surgical concepts as presented in the book, however, differ substantially from those practiced by us and by most neurosurgeons in this country. The palmar incision, for example, does not need to cross the wrist crease in any but the most unusual circumstances. As the author himself has shown so well in several pictures in this book, the site of median nerve compression, in most cases, is in the palm and not at the wrist. In many instances, the scar crossing the wrist crease retracts, becomes painful, and limits wrist dorsiflexion. In fact, we had to extend our incision beyond the wrist

crease in only one patient in well over 100 operations.

Similarly, we do not recommend the use of tourniquet during surgery or splints postoperatively as the author has suggested. Instead, the hemostasis is achieved using bipolar cautery and the procedure is done under local anesthesia. Patients start active rehabilitation including the full use of the operated hand 72 hours after surgery and usually return to work in three weeks.

In conclusion, the book contains useful information but the surgical concepts seem a bit outmoded.

Otakar R. Hubschmann, M.D.

The Clinical Consultations of Giovanni Morgagni, The Edition of Enrico Benassi (1935)

Saul Jarcho (ed). Boston, MA, The Francis Countway Library of Medicine, 1984.

Among the pivotal figures in the history of 18th century medicine, few rank higher than Giovanni Battista Morgagni (1682-1771) who during a long lifetime raised pathologic anatomy to the status of a true science. However, it generally is not known that in addition to having performed some 600 to 700 postmortems, Morgagni, professor of medicine at Padua, maintained an active clinical practice and was consulted by numerous patients and physicians from all parts of Italy and Europe. From his numerous case reports or "consilia," the master selected for the benefit of a favorite pupil exactly 100 which form the bulk of this fascinating and important book.

Although in most cases he did not have the advantage of a personal examination of the patient, Morgagni seems invariably positive in his diagnosis, being assisted by his profound understanding of the pathology underlying the symptoms. As for treatment, he is quite conservative in surgical cases, preferring the healing powers of nature to radical intervention, e.g. Case VI of a lacerated tongue; on the other hand, being a confirmed humoralist his herbal armamentarium included no less than 400 items—most of which today are considered to be

therapeutically valueless.

It is rare to find a work of such magnitude and complexity edited so carefully—one might almost say so lovingly. Working from the Italian translation, Dr. Jarcho—who already had written extensively on Morgagni—has added notes, commentaries, and appendices, all of which assist us to a fuller understanding of the contents of the consultations. I believe that the present volume soon will be regarded as a classic of American scholarship: it should become required reading for anyone seriously interested in the development of medical education in the period just prior to the rise of the Enlightenment.

Morris H. Saffron, M.D.

Symptoms and Signs in Cardiology

Horvitz and Groves (eds). Philadelphia, PA, Lippincott Publishing Co., 1985. Pp. 506. Illustrated. (\$39.50)

The editors state that the purpose of this book is to provide comprehensive discussions of the pathophysiology and clinical characteristics of signs and symptoms commonly encountered by physicians who care for patients with cardiac disease.

There are 17 chapters. Each of the first 10 chapters discusses in detail a symptom or sign(s) of cardiac disease. The format for each chapter is: definition of the subject, physiology, clinical presentation, and summary. Chapters 11 to 15 discuss specific disease entities, e.g. congestive heart failure, pulmonary embolism, cardiac tamponade and constriction, pulmonary hypertension, and systemic hypertension. The last 2 chapters cover nuclear cardiac imaging and echocardiography. Each chapter is followed by a list of citations. The index and table of contents adequately cross-reference the material in the text.

The scope of this book requires that it be compared to standard textbooks of the heart. In doing so, the first 11 chapters were not found to have conveyed any significantly greater or detailed information. The bibliography of each of the first 11 chapters seldom has a reference more recent than 1975. The chapters dealing with murmurs, venous pulsations, and heart sounds do not add anything over Morton E. Tavel's,

Clinical Phonocardiography and External Pulse Recording, 2nd Edition, (Year Book Medical Publishers, 1973). The chapters on congestive heart failure, and systemic and pulmonary hypertension are equally well covered in standard texts. The chapters on echocardiography and nuclear cardiology say nothing new on either topic and this information is better covered in other sources. One wonders how these last 2 chapters were topically attached to the first 15 chapters and how they fit the book's title unless interpreted broadly.

In summary, this book is a reworking of old material using a somewhat different format. By its selection of only certain specific topics it avoids the necessity of completeness required by a textbook. I

disagree with the editors when they say that this book will be of interest to a wide spectrum of physicians. It conceivably may be employed as a teaching reference text for physicians-in-training but with good standard reference texts already available, I doubt it.

Robert M. MacMillan, M.D.

Physician's Handbook, 21st Edition

Krupp, Tierney, Jawetz, Roe, Camargo (eds). Los Altos, CA, Lange Medical Publications, 1985. Pp. 800. Illustrated. (\$16.50)

The idea of having a "pocket compendium of essential medical facts" in 33 chapters covering "the gamut of medical practice from cardiopulmonary resuscitation to diagnosis

and treatment of endocrine disorders, mycotic infections, and parasitic disease" is attractive. Whether such an endeavor may be accomplished or not, is another matter.

This is a book that attempts to compile, in 800 pages, physical examination, diagnostic techniques (from electrocardiography to MR imaging), laboratory techniques and interpretation of results, toxicology, and pharmacology—just to mention some of the topics; the results are predictable: oversimplifications are numerous, obsolescence is found (page 293, the Alcohol Test Meal for gastric acid output determination is described, something no longer done), and recommendations that are not up to date occur. I cannot recommend this book.

Geobel A. Marin, M.D.

**Drs. Ballou; Gould; Hayes;
Maquiling; Monaco;
Ratcliffe; Seaton;
Vol-Tretter**

Dr. Robert A. Ballou

A Point Pleasant ophthalmologist, Robert Anthony Ballou, M.D., died on June 25, 1985, while vacationing at Chateau Lake Louise, Canada. A native of New Brunswick, born in 1925, Dr. Ballou received his medical degree from New York University School of Medicine in 1950. A member of our Ocean County component, and of the American Medical Association, Dr. Ballou was board certified in his specialty, and was a Fellow of the American College of Surgeons and of the American Academy of Ophthalmology and Otolaryngology. He had been affiliated with Point Pleasant Hospital and Kimball Medical Center, Lakewood.

Dr. Louis F. Gould

Louis Frederick Gould, M.D., a

member of our Middlesex County component, died on July 16, 1985. Born in 1918, Dr. Gould received his medical degree from New York University School of Medicine in 1942. After serving in the Navy from 1942 to 1947, Dr. Gould was affiliated with the Medical Division, Bellevue Hospital, New York. An internist, Dr. Gould was a member of the American Medical Association and an attending at Perth Amboy General Hospital.

Dr. Gerald W. Hayes

At the age of 79, Gerald Weldon Hayes, M.D., died on July 7, 1985, at the Veterans Administration Medical Center, Lyons. Dr. Hayes earned his medical degree from Northwestern Medical School, Illinois, in 1932. He was former chief of staff at Saint Michael's Medical Center, Newark, and former chief of obstetrics at Saint Mary's Hospital, Orange. A member of our Essex County component, Dr. Hayes was a Diplomate of the American Board of Gynecologic Oncology, a Fellow of the American College of Obstetricians and Gynecologists, and a member of the American Medical Association. In 1982, Dr. Hayes was awarded MSNJ's Golden Merit Award for his 50 years of service to his community.

Dr. Renerito M. Maquiling

At the untimely age of 49, Renerito Materdo Maquiling, M.D., died on July 16, 1985. Born in the Philippines, Dr. Maquiling came to the United States in 1963; he had received his medical degree from the University of Santo Tomas Medical School in 1962. A family practitioner in Hazlet Township, Dr. Maquiling was affiliated with Bayshore Hospital, Holmdel; Riverview Hospital, Red Bank; and Monmouth Hospital, Long Branch. Dr. Maquiling, a member of our Monmouth County component, also was a member of the American Medical Association.

Dr. Dante P. Monaco

Dante Peter Monaco, M.D., a surgeon for 44 years at Columbus Hospital, Newark, died on July 17, 1985. Born in 1910 in Montclair, Dr. Monaco received his medical degree from Royal University of Naples, Italy, in 1939. A member of our Essex Coun-

ty component, Dr. Monaco also was affiliated with St. Vincent Hospital and Community Hospital, both in Montclair. Dr. Monaco was a member of the American Medical Association, and a Fellow of the International College of Physicians and Surgeons.

Dr. John W. Ratcliffe

At the age of 59, John Wesley Ratcliffe, M.D., died on July 13, 1985. Born in Wayne, Dr. Ratcliffe earned his medical degree from New York University School of Medicine in 1949. Dr. Ratcliffe remained in his hometown where he opened a practice in 1950; for the next 28 years, Dr. Ratcliffe specialized in pediatrics and then in obstetrics and gynecology. A member of our Passaic County component and of the American Medical Association, Dr. Ratcliffe was affiliated with General Hospital, Wayne; Valley Hospital, Ridgewood; and Chilton Hospital, Pompton Plains.

Dr. R. Kirk Seaton

At the untimely age of 44, Robert Kirk Seaton, M.D., director of Phillips-Barber Family Health Center, Lambertville, died on July 9, 1985, at Hunterdon Medical Center. Born in New Brunswick, Dr. Seaton obtained his medical degree from the University of Pennsylvania School of Medicine, Philadelphia, in 1966. He was a Diplomate in the specialty of family practice, a member of our Hunterdon County component, and had served on the board of trustees of Hunterdon Medical Center, Flemington, for the past five years.

Dr. Marta Vol-Tretter

At the grand age of 93, Marta Vol-Tretter, a prominent Trenton physician, died on July 15, 1985. Born in Latvia, Dr. Vol-Tretter completed her medical education at Karl Franz University Medical School, Austria, in 1927. During her lengthy career, Dr. Vol-Tretter was director of the mental department at Trenton General Hospital, and owned and operated the Syvan Nursing Home, West Trenton. Dr. Vol-Tretter was a member of our Mercer County component, of the American Medical Association, and of the American Psychiatric Association.

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**Personnel
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Style Sheet

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CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

manuscript based on a presentation made in New Jersey.

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SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the

source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.
2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

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Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

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All communications should be sent to the Editor, *New Jersey Medicine*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

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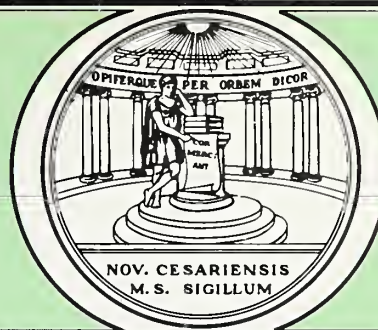
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MEMBERSHIP NEWSLETTER



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THE MEDICAL SOCIETY OF NEW JERSEY

VOLUME 27

MALPRACTICE INSURANCE SUBORDINATED LOAN TAXABILITY, MEDICAL INTER-INSURANCE EXCHANGE

Several months ago you were advised that the Tax Court had rendered a decision in the above case which was brought as a class action by the Medical Society of New Jersey.

After careful analysis the Society decided not to litigate further. The IRS has made a similar decision.

The IRS is processing assessments for all unincorporated physicians and for professional corporations where the statute of limitations has not expired. In regard to most professional corporations and many individuals who joined the Exchange in 1977, 1978, 1979, 1980, and 1981, the statute of limitations already may have expired. **Please check this possibility with your accountants before agreeing to any assessments. If you or they have any questions, please call Terence Heaney, Esq., 215-337-4080.**

CONTROL OF SEVERE CANCER PAIN

New information on control of severe cancer pain is related by Prescott (*Medical Tribune* 25:1, October 1984). Researchers have discovered that when patients suffering with severe pain were given a combination of piroxicam (Feldene[®]) and doxepin (Sinequan[®]), their pain was relieved as well as or better than with narcotics. Thirteen of 16 patients stopped taking narcotics within the first weeks of starting therapy with doxepin (50 mg orally at bedtime) and piroxicam (40 to 120 mg daily). The nonsteroidal anti-inflammatory drug appears to act directly on the central nociceptive transmission, whereas the tricyclic drug acts directly on the central nervous system.

SMOKING—FRIEND OR FOE?

The Burlington County Medical Society has produced a 30-minute videotape suitable for VCR or commercial station use entitled, "Smoking—Friend or Foe?" It is a dramatic portrayal of the hazards of smoking. It is aimed for the 11 to 16 age group, but there was considerable acceptance by educators, service clubs, and business groups. Copies can be borrowed by calling Mrs. Catherine Pegues, 609-654-5255 or Mrs.

Shirley Greene, American Cancer Society of New Jersey, 201-297-8000.

AMA-HOSPITAL MEDICAL STAFF SECTION

There will be a meeting of the AMA-Hospital Medical Staff Section on December 5 to 9, 1985, at the Shoreham Hotel, Washington, D.C. The theme for this meeting is "Physicians in the 90's."

GREAT AMERICAN SMOKEOUT

The American Cancer Society is conducting the Great American Smokeout on November 21, 1985. They request all smokers to refrain from smoking on this day.

PHYSICIANS RADIO NETWORK

Physicians Radio Network (PRN) was founded in 1974 to provide a 24-hour-a-day medical news and information service for physicians. Today the Network covers 38 markets—over 75 cities—nationwide. To achieve the "closed circuit" capability, PRN utilizes FM sidebands known as "SCA's" (Subsidiary Communications Authorizations) to deliver the program to specially tuned, one-station radios in each market.

PRN's audience totals over 73,000 physicians who have requested radios. In response to advertiser interests, the Network is investing in the expansion of the "core" listener base—general practitioners, family practitioners, internists, cardiologists, and gastroenterologists who are MD's and osteopaths. Of PRN's total audience, approximately 60 percent are specialists in the core group.

PRN reaches almost 40 percent of all internists and 30 percent of all general and family practitioners. These physicians receive PRN radios free upon request. For interested physicians outside the core group, there is a one-time subscription fee to cover the cost of the radio and receipt of the PRN Radio Guide. A new portable radio, usable in the doctor's car, is available.

Programming includes coverage of major medical conventions, news conferences, journal reviews, interviews, and conference calls with leading clinicians and

TABLE

Question	Percentage High & Very High		Question	National	New Jersey
	1984	1985			
			Doctors don't include patients/treatment	*	67
			Medical care is becoming too specialized	*	67
Ethical Standards			People become doctors for money/prestige	66	67
Clergy	68	66	Doctors spend enough time with patients	34	38
Pharmacists	69	61	Doctors are too quick to prescribe drugs	*	72
Lawyers	25	21	Doctors give good advice/nutrition/etc.	*	73
Medical Doctors	59	46	Doctors don't make more mistakes than 10 years ago	*	51
Dentists	61	55	Doctors keep good health products off market	*	39
TV Newscasters	*	32	Doctors make too much money	*	64
Question	Percentage Agree	Percentage Yes	Question	National	New Jersey
	1984	1985		1984	1985
Doctors are accessible in an emergency	53	55	Stand/limit on amount of malpractice award	61	55
Doctors' fees are reasonable	27	28	Anything bother you/last doctor visit	*	41
People are losing faith in doctors	68	68			
Doctors explain things well	44	47			
Doctors are too interested in making money	67	68			
A growing crisis/malpractice suits and awards	*	85			
Doctors act like they're better/others	38	43			
Doctors take a genuine interest in patients	62	72			
Poor people get needed medical care	43	45			
Doctors discuss fees before treatment	*	37			
Doctors are usually up to date on the latest medical advances	71	68			
Elderly are able to get medical care	51	49			
Doctors don't care about people as much as they used to	54	58			
Medical science saves many	94	93			
Physicians are involved in local activities	*	37			
Government provides better health care for the poor and elderly	*	82			
Lawyers' fees are usually reasonable	19	20			
Important for people/own personal physician	*	92			
Doctors keep patients waiting too long	*	75			
People become doctors to help other people	51	58			

others involved in the practice of medicine. In addition, PRN's staff writers develop and present feature programs designed to offer practical and immediately useful information to primary care providers.

All physicians with PRN radios receive the PRN Radio Guide monthly with a calendar of upcoming programs.

For additional information contact Physicians Radio Network, Inc., One Dock Street, Stamford, CT 06902, 203-324-1700.

PUBLIC IMAGE OF PHYSICIANS

Physicians are aware that the medical profession has a "public image" problem (Table). Most physicians

agree that public perceptions and relations are important. There is a need to focus more attention on the physician's role as a patient advocate.

The perceptions of the medical profession by the public reflect an "image gap." The majority of patients do not believe doctors are reasonable. They are of the opinion that doctors do not spend enough time with their patients. They do not feel that doctors explain enough about the patient's health problem.

The eroding image of the medical profession—the image gap—has most important connotations for physicians. It makes it difficult for physicians to act as patient advocates. It promotes a cloud of self-interest over the Medical Society's efforts to influence legislation and its public service programs. It negates public support and encourages those forces which want to further regulate the delivery of health care.

A continued erosion of the doctor/patient relationship will make it increasingly difficult for physicians to maintain their status, their incomes, or even their

right to practice good medicine as ever-increasing segments of the population conclude that doctors are greedy and uncaring.

Physicians must do a better job of telling medicine's side of the story to the public. The patients do not mind paying a reasonable fee for service if they are treated with courtesy and kindness. A cordial and discreet staff is a tremendous asset. A schedule that is not overbooked and on time is a major plus.

Doctors have to be prepared to speak out not only in defense of their position but also to explain the vast changes that are affecting the delivery of health care.

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LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
S-70 Codey	To change requirements for eligibility to be Commissioner of Health	Active Opposition	Senate: IHW	In committee
S-111 Bubba	To require a physician to present surgical consent forms at the time surgery is agreed upon	Active Opposition	Senate: LIP	In committee
S-243 Hagedorn	To provide procedures for involuntary civil commitment of the mentally ill	Active Opposition	Senate: IHW	In committee
S-424 Dorsey	To provide for the abolishment of certain state agencies for specific periods of time and to create a Joint Legislative Committee on Regulatory Agencies	Active Support	Senate: SGF&IR&VA	In committee
S-607 Bassano	To require the padding of all metal bars in school buses with energy-absorbing materials to be included in the State Board of Education's rules and regulations	Active Support	Senate: LPS&D	In committee
S-723 Brown	To require the State Department of Health to prepare a booklet on breast cancer and require physicians to give a copy of the booklet to breast cancer patients	Active Opposition	Senate: IHW	In committee
S-752 Hirkala	To provide that certain information of hospitals and long-term health care facility review committees be considered confidential	Active Support	Senate: IHW	In committee
S-754 Hirkala	To provide immunity from civil liability to members of hospital governing bodies in connection with certain review actions	Active Support	Senate: J	In committee
S-1067 Feldman	To establish and license two categories of social workers	Active Opposition	Senate: IHW	In committee
S-1079 Dumont	Provides for a 3-year statute of limitations, except for fraud, intentional concealment, or nontherapeutic or diagnostic purpose. Minors have until age 11 for any injury prior to age 8	Active Support	Senate: J	In committee
S-1112 Hurley	To establish a cap on the amount of damages which may be awarded for pain and suffering in certain civil actions	Active Support	Senate: J	In committee
S-1135 Dalton	To eliminate certain sources of windfall benefits in personal injury and wrongful death actions	Active Support	Senate: J	In committee
S-1140 Feldman	To impose certain requirements on the plaintiff in a medical malpractice proceeding	Active Support	Senate: J	In committee

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
S-1182 Saxton	To establish the Automobile Insurance Medical Fee Schedule Board	Active Opposition	Senate: LIP	In committee
S-1190 Feldman	To authorize a court to award reasonable attorney's fees to a party who prevails against a frivolous claim for relief in a civil action	Active Support	Senate: J	In committee
S-1775 Orechio	Allows chiropractors who are licensed to practice by written examination in any state and who have completed 4,300 classroom hours in a chiropractic school to become licensed to practice by virtue of a clinical examination	Active Opposition	Senate: LIP	Signed into law as c. 255 P.L. 1985
S-1840 Cardinale	Exempts the private practice of medicine from the certificate of need law	Active Support	Senate: IHW	In committee
S-1846 Garibaldi	Provides that cancers caused by exposure to heat, cold, radiation, or a known carcinogen which manifest themselves in active police or firemen are assumed to be accidental and work-related disabilities	Active Opposition	Senate: SGF&IR&VA	In committee
S-2019 Lynch	Creates the profession of contact lens dispensing and fitting for nonphysicians and nonoptometrists. Licensure and regulation would be through the Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians. A prescription by a licensed optometrist or physician would be required	Active Opposition	Senate: LIP	Passed in Senate; in Assembly Committee C1
S-2116 Bassano	Requires physician to inform women undergoing abortions of availability of fetal anesthesia whenever the fetus to be aborted is viable, i.e. able to live outside the womb with or without artificial means of support. Act is not applicable during an emergency, or if the anesthesia decreases the possibility of survival of fetus, or if the anesthesia to the mother will also abolish organic pain to the aborted fetus	Active Opposition	Senate: LIP	Bill referred to Senate Judicial Committee
S-2159 Hagedorn	Substantially alters the involuntary commitment law. Significantly, certification may be effected by psychologists, nurses, or social workers who have conducted examination within the three days prior to certification	Active Opposition	Senate: J	In committee

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
S-2379 Costa	Provides that consulting physicians are not to be reimbursed unless the patient has agreed, in writing, prior to consultation. Substantial incapacity of patient and mandatory consultation as a result of law, hospital rule, or insurance contract are excepted	Active Opposition	Senate: IHW	In committee
S-2544 Bubba	Requires written consent to surgery except in cases of physical or mental incapacity or emergencies. The State Board, after consultation with the Health Dept., MSNJ, and NJHS, shall prescribe the consent forms which shall be used by physicians	Active Support	Senate: LIP	In committee
S-2711 Hagedorn	Requires a second physician to be present at any termination of pregnancy procedure if the attending has determined the unborn fetus is 24 weeks of age or older. The second physician is to provide immediate care to the child if it is born alive	Active Opposition	Senate: IHW	In committee
S-2712 Hagedorn	Requires the SBME to conduct a study as to when fetal viability occurs so that the conduct of physicians may be governed accordingly. Having conducted such a study, the Board is to promulgate guidelines regarding the termination of pregnancy	Active Opposition	Senate: IHW	In committee
S-2740 Bassano	Deletes the requirement of a certificate of need for cardiac surgical centers. The hospital still would have to comply with Dept. of Health rules and regulations governing these units	Active Support	Senate: IHW	In committee
S-2869 Codey	Amends certificate of need to include physicians whenever a health service has been regionalized by regulation of the Dept. of Health. Regulation would terminate within three years, at which time, the Commissioner could readopt the regulation	Active Opposition	Senate	Out of committee; 2nd reading
S-2922 Hagedorn	Creates a commission to study the adequacy of rates allowed for nursing homes and the quality of care rendered to patients in nursing homes	Active Support	Senate: IHW	In committee

LEGISLATIVE ALERT

S-2869-Codey—Health Care Facilities Act/Certificate of Need. S-2869 has been reported out of committee. This bill presents a clear and present danger to the private practice of medicine. Every member of the Medical Society of New Jersey should write and call their Senator and Assemblymen and request a "NO" vote on this bill.

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
A-115 Otlowski	To authorize optometrists to prescribe a limited number of eye medications	Active Opposition	Assembly: HERP	In committee
A-708 Hardwick	To create a temporary committee to study Diagnosis Related Group System used for setting hospital rates and appropriate \$45,000	Active Support	Assembly: CHHS	In committee
A-926 Weidel	To create an Automobile Insurance Fee Schedule Board in the NJ Dept. of Insurance to adopt a reasonable fee schedule for medical services arising from passenger automobile accidents	Active Opposition	Assembly: BI	In committee
A-960 Miller	To permit individual patients or insurers to appeal hospital bills in cases of assignments under DRG	Active Support	Assembly: CHHS	In committee
A-963 Miller	To eliminate DRG methodology and replace it with one to be devised by the New Jersey Department of Health in one year	Active Support	Assembly: CHHS	In committee
A-1056 Muziani	To require attending physicians and certified nurse midwives to inform pregnant women of any drugs expected to be used during pregnancy and the possible effects thereof	Active Opposition	Assembly: CHHS	Out of Senate committee; 2nd reading
A-1158 Herman	To require licensed physicians or chiropractors to notify the State Board of Medical Examiners if they accept Medicare assignments	Active Opposition	Assembly: HERP	In committee
A-1471 Garvin	To require a physician to obtain, in advance, the patient's authorization to perform a biopsy or mastectomy	Active Opposition	Senate: IHW	Signed into law as c. 1985 P.L. 1984
A-1541 Karcher	To provide for the licensing of persons who practice hypnosis and limit the practice, teaching, or preparation of hypnosis tapes to licensed practitioners	Active Opposition	Assembly: HERP	Out of committee; 2nd reading; amended
A-1559 Garvin	Requires Dept. of Health and the State Board of Medical Examiners to prepare a booklet on all aspects of the treatment of breast cancer. Physicians are required to distribute the book to appropriate patients and to discuss it with them	Active Opposition	Assembly: CHHS	Passed in Assembly. In Senate IHW Committee
A-1682 Muhler	Creates a seven-person Board within the Department of Human Services vested with the authority to release or continue the commitment of persons who were found incapable of standing trial or not	Active Opposition	Assembly: CHHS	In committee

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
	guilty by reasons of insanity. A Superior Court judge currently makes these decisions			
A-1870 Garvin	Amends existing statutes to require either seat belts or restraint systems for all children under ten in a motor vehicle. Current law applies to children under age five	Active Support	Assembly: CI	In committee
AR-31 Herman	Requests the Commissioner of Health to educate the public, particularly young people, about the dangers of cigarette smoking	Active Support	Assembly: CHHS	In committee
A-1918 Miller	Provides that collateral sources of payment shall be used to offset damages. Further provides structured payments may be used at the request of either party if the future damages exceed \$100,000	Active Support	Assembly: JUD	In committee
A-1919 Miller	Provides a \$100,000 cap on damages for pain and suffering to personal injury actions	Active Support	Assembly: JUD	In committee
A-1921 Miller	Establishes a 3-year statute of limitations in tort actions against health care providers. Children would have until age 11 to bring action for injuries prior to age 8. After age 8, they come under the 3-year standard. Fraud, concealment, and unintentional foreign bodies "toll" the statute	Active Support	Assembly: JUD	In committee
A-1922 Miller	Provides that within 60 days of filing a medical malpractice complaint, the plaintiff must supply an affidavit, by a qualified expert, that reasonable cause exists to believe malpractice occurred	Active Support	Assembly: JUD	In committee
A-2106 Paterniti	Requires nursing homes with 100 beds or more to dedicate 10 percent of bed capacity to indigent, 10 percent to complex care, and 10 percent for medical day care services	Active Opposition	Assembly: CHHS	In committee
A-2115 Otlowski	Permits optometrists to use topical drugs for treatment and diagnostic purposes	Active Opposition	Assembly: CHHS	Returned to committee
A-2122 Cooper	Establishes seating restraint and emergency exit requirements for school buses	Active Support	Assembly: ED	In committee
A-2140 Rooney	Provides that a judge may order a juvenile offender to be examined by a physician, optometrist, or audiologist	Active Opposition	Assembly: JUD	Out of Senate committee; 2nd reading

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
A-2293 Kalik	Appropriates \$9.45 million for the UMDNJ Osteopathic School in Stratford	Active Opposition	Assembly: RFA	Signed into law as c. 4 P.L. 1985
A-2304	To require that the driver and passengers in the front seat of an operating passenger automobile wear the safety seat belt provided	Active Support	Assembly: LPSD	Signed into law as c. 179 P.L. 1984
A-2757 Kern	Empowers the SBME to license and regulate nurse-midwives. Creates five-member Nurse-Midwives Examining Committee which would have the power to license and regulate nurse-midwives. Committee would have stipulated, delegated powers from Board and would function independent of Board	Active Opposition	Assembly: HERP	In committee
A-2889 Herman	Provides for separate licensing board to register physician assistants who would function under the supervision of a licensed physician at the 2:1 ratio	Active Opposition	Assembly: CHHS	In committee
A-3310 Hardwick	Provides for structured payments in cases exceeding \$100,000 liability in future damages. Prohibits punitive damages in medical malpractice cases	Active Support	Assembly: JUD	In committee
A-3111 Hardwick	Requires the Court to award attorneys' fees to the prevailing party if the other side has been guilty of frivolous actions	Active Support	Assembly: JUD	In committee
A-3254 Muziani	Directs the SBME to conduct a scientific study to determine when fetal viability occurs	Active Opposition	Assembly: CHHS	In committee
A-3255 Muziani	Requires a second physician to be present when a physician terminates a pregnancy involving a live fetus of 24 weeks or older	Active Opposition	Assembly: CHHS	In committee
A-3397 Bocchini	Allows an emergency medical technician to serve on a mobile unit in place of a paramedic or registered nurse	Active Opposition	Assembly: CHHS	Passed in Assembly; in Senate committee
A-3469 Kern	Provides for local planning councils to replace the health systems agencies. These would be funded by an assessment levied against all NJ hospitals	Active Opposition	Assembly: CHHS	In committee
A-3558 Kosco	Creates a commission to study the certificate of need process. The commission would consist of 15 members; two would be physicians. Their report is to be sub	Active Opposition	Assembly: CHHS	In committee

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
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mitted to the legislature and governor

A-3646 Vainieri	Prohibits physicians from performing elective surgery unless the patient has secured a second surgical opinion prior to the surgery	Active Opposition	Assembly: CHHS	In committee
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Senate Committee Key

ED: Education
 IHW: Institutions, Health and Welfare
 J: Judiciary
 LIP: Labor, Industry and Professions
 LPS&D: Law, Public Safety and Defense
 SGF&IR&VA: State Government, Federal & Interstate Relations & Veterans Affairs

Assembly Committee Key

BI: Banking and Insurance
 CHHS: Corrections, Health and Human Services
 CI: Commerce and Industry
 ED: Education
 HERP: Higher Education and Regulated Professions
 JUD: Judicial
 L: Labor
 LPSD: Law, Public Safety and Defense
 RFA: Revenue, Finance and Appropriations

LOYAL SUPPORT: Scores of physicians have responded to MSNJ's Medical Action Committee (MedAC) drive to improve medicine's participation in the legislative election campaigns. MedAC will amplify on ongoing state activities through JEMPAC. Major issues facing medicine are malpractice and general tort reform and the application of certification of need to physicians' practices. On behalf of all our members, President Ralph J. Fioretti, M.D., would like to thank the many who have responded generously, and those who we are sure will join them.

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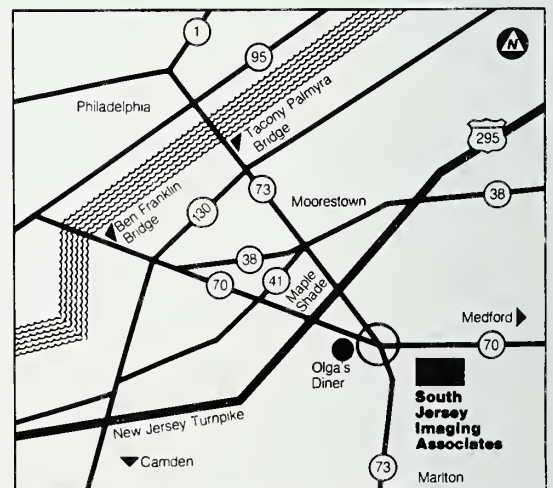
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Task Force Submits Report

The Commissioner's Task Force on Medical Malpractice submitted its recommendations for reform.

The Commissioner's Task Force on Medical Malpractice was created in 1984 by former Commissioner Kenneth Merin. The 15-member Task Force, composed of physicians, insurers, attorneys, and a nurse, had two charges: 1) to recommend measures that might reduce the incidence of medical malpractice as well as stabilize the cost of medical malpractice insurance and 2) to recommend an equitable method of funding the projected \$40 to \$50 million deficit of the New Jersey Medical Malpractice Reinsurance Association.

The Task Force has completed its first charge and has submitted 14 recommendations to the present Commissioner of Insurance, Hazel F. Gluck. According to Commissioner Gluck, many of the recommendations will call for legislative reform; others can be instituted through the cooperation of the State Supreme Court, the New Jersey Bar Association, the New Jersey State Board of Medical Examiners, and New Jersey's professional medical and dental societies.

The Task Force recommendations are as follows:

1. Amend the collateral source rule. At present, plaintiffs can be awarded losses that already are covered by other insurance, such as health insurance. In effect, the plaintiff is compensated twice. The Task Force recommends the law be changed so that plaintiffs are not paid a second time for economic losses.

2. Restrict the statute of limitations for adults to four years. At present, adults either have two years from the date of the incident or two years from the date of the discovery of the injury to file. Under this system, a plaintiff can file suit many years after an incident, making it difficult for insurance companies to project

risk. Another problem is that the older a case, the more difficult it becomes to reconstruct facts. The Task Force recommendation would give adults four years to file, no matter when the injury was discovered, with exceptions in cases where there was fraud or a foreign object left inside a surgical patient.

3. Amend the statute of limitations for minors. Current law permits children to file claims until two years after their 18th birthday, no matter when the injury. The Task Force recommends children have until age 11 to file for injuries which occurred when they were 8 or younger. This recommendation would spur parents to file for injuries earlier, and make it possible to price insurance for obstetricians/gynecologists with more accuracy.

4. Eliminate a hospital's immunity to suits of more than \$10,000. At present, almost all hospitals enjoy immunity from liability verdicts of \$10,000 or more if they are nonprofit institutions. However, 78 percent of all claims filed against physicians involve the hospital as the site of the injury. By removing the immunity from hospitals, all hospital employees would be included in suits brought against the hospital without the plaintiff having to name each employee as a separate defendant. This measure also would better coordinate defense of a suit.

5. Require plaintiffs to file an affidavit of reasonable cause within 60 days of filing a suit. The affidavit, which must be signed by a physician, is intended to eliminate the weakest cases early and save court time and costs.

6. Institute mandatory arbitration for malpractice cases with claims of \$50,000 or less. At present, there is no arbitration system for medical malpractice. The Task Force recommends setting up a system modeled after the one used for automobile insurance. Although the findings would be nonbinding, should a party appeal and lose, they would risk sanctions.

7. Create a pool of better qualified expert witnesses. At present, plaintiffs have difficulty finding local, qualified expert witnesses. As a result, a witness many times comes from out of state, or is not a specialist in the same field as the defendant. The Task Force recommends that the state's medical and dental societies create a local pool of specialists available to serve as expert witnesses.

8. Strengthen the State Board of Medical Examiners. The Board of Medical Examiners is understaffed. The Task Force recommends increasing its staff and speeding up its computerization so that it can become a stronger watchdog on the physician community.

9. Amend legislation requiring that all claims of \$25,000 or more be transferred to the Board of Medical Examiners. The Task Force recommends that a better trigger mechanism would be whenever payment of a claim is \$100,000 or more, or whenever a physician has had three or more claims in five years.

10. Require medical students to take courses focused on ethics, risk management, and the legal issues related to medical malpractice. Most medical

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Director of Special Projects.

schools do not require courses in these areas.

11. Require continuing education for physicians.

Although state medical and osteopathic societies require continuing education, not every physician is a member of these societies. The Task Force recommends physicians take 150 hours of continuing education every three years as a requirement for licensure.

12. Encourage physicians to better explain all ramifications of a procedure to patients. Too many suits are filed because a physician did not fully explain all possible outcomes of a procedure.

13. Create a special certified malpractice attorney program. To be modeled after the certified trial lawyer program, this recommendation is seen as a way to cut down on the number of unwarranted suits and inefficient court practices.

14. Institute a peer review program for lawyers. This program would be similar to the physician peer review now utilized in hospitals.

The Task Force will be presenting recommendations to the Commissioner in the near future regarding the deficit of the New Jersey Medical Malpractice Reinsurance Association.

The Task Force was composed of representatives of the medical, legal, and insurance fields chosen to represent their fields, and to represent the citizens of New Jersey. Task Force members represent all geographic areas of the state, as well as a cross-section of specialties within their respective fields. Task Force members included:

1. Jesse W. Benton Jr., of Chatham, executive director of the New Jersey Medical Malpractice Reinsurance Association. Benton, former president of the Chubb Foundation and a former director of Chubb & Son Inc., is executive director and secretary of the New Jersey Property-Liability Insurance Guaranty Association.

2. Stanley David, D.P.M., of Cinnaminson, is former president of the New Jersey Podiatric Society. A practicing podiatrist for over 25 years, Dr. David is on the staff of John F. Kennedy Memorial Hospital in Cherry Hill, Stratford, and Turnersville with a private office in Woodbury.

3. Michael J. Doyle, M.D., of Mantoloking, is the chairman of the board of directors of the New Jersey Academy of Family Physicians and chairman of the insurance committee of the Medical Society of New Jersey. On the staff of the Jersey Shore Medical Center, Neptune, and the Monmouth Medical Center, Long Branch, Dr. Doyle maintains a family practice in Neptune. Dr. Doyle is chairman of the Medical Defense and Insurance Committee of the Medical Society of New Jersey, a delegate to the National Congress of the American Academy of Family Physicians, and a member of the Ad Hoc Committee on Professional Liability, American Academy of Family Physicians.

4. John Durst, M.D., who practices in Freehold, is a former president of the Monmouth County Medical Society. Dr. Durst has been a member of the Medical Society of New Jersey's House of Delegates for 11 years.

5. Louis G. Fares, M.D., of Trenton, is director of surgery at St. Francis Medical Center, Trenton. A clinical assistant professor of surgery at Hahnemann Medical School in Philadelphia, Dr. Fares is a member

of the board of trustees of New Jersey Blue Shield and of the American Cancer Society.

6. Lars Hyberg is an attorney with the firm of Valore, McAllister, Westmoreland, Gould, Vesper & Schwartz which has offices in Northfield, Atlantic City, and Wildwood.

7. Sandford M. Lewis, M.D., of South Orange, is a member of the State Board of Medical Examiners. He is former chairman of the Health Care Administration Board of New Jersey and maintains a practice in West Orange.

8. Robert S. Maurer, D.O., a general practitioner in Iselin and Avenel, is on the staff of JFK Medical Center, Edison, and Memorial General Hospital, Union. He is chairman of the New Jersey Osteopathic Education Foundation and is a board member of the New Jersey State Medical Underwriters, Inc.

9. Alan Y. Medvin, of Princeton, has completed a one-year term as president of the New Jersey affiliate of the Association of Trial Lawyers of America. A partner of the Newark law firm of Medvin and Elberg, Medvin specializes in cases involving significant personal injury, medical malpractice, and product liability.

10. Gerald B. O'Connor is a partner in the Newark law firm of O'Connor and Rhatican. A certified civil trial attorney, O'Connor is former president of the Trial Attorneys of New Jersey.

11. Joseph A. Riggs, M.D., of Haddonfield, is chief of gynecology at Our Lady of Lourdes Medical Center, Camden. A former member of the State Board of Medical Examiners, Dr. Riggs is president of the Camden County Medical Society. Dr. Riggs has offices in Haddonfield and Ocean City.

12. Jill S. Slattery of Short Hills, is a lawyer and a nurse who specializes in nursing law. She maintains a private practice in Montclair. A member of the executive committee of Essex County Women Lawyers, she served on the State Supreme Court's Essex County Medical Malpractice Panel.

13. Donald E. Smith is vice-president of the Health Care Insurance Exchange and the Princeton Insurance Co. Smith has been involved in the underwriting of medical malpractice insurance since 1968.

14. Peter Sweetland, of Lawrenceville, is president of the New Jersey State Medical Underwriters, Inc. and the Medical Inter-Insurance Exchange of New Jersey. He also is administrator of the Physician Insurers Association of America, a nationwide organization of insurance companies sponsored by medical societies and owned by physicians.

15. Carl J. Valore is a senior partner with Valore, McAllister, Westmoreland, Gould, Vesper & Schwartz, a firm with offices in Northfield, Atlantic City, and Wildwood. He is a certified civil trial attorney who specializes in medical malpractice law and hospital law. He is the general counsel for Burdette Tomlin Memorial Hospital, a fellow of the American Academy of Hospital Attorneys, and a member of the New Jersey Society of Hospital Attorneys, and of the Board of Governors of the Association of Trial Lawyers of America.

16. Herbert Dolinsky, D.D.S., is an advisory member of the Task Force and practices dentistry in Jersey City. He is on the staff of the Jersey City Medical Center, Christ Hospital, Bayonne Hospital, and the Jewish Hospital and Rehabilitation Center.

Public Service and Ethical Norms

WILLIAM L. TROMBETTA, J.D., PH.D.*

The medical profession stands to gain a great deal from a "public service and ethical norms" standard applied to health care trade restraint challenges.

In 1982, the Supreme Court continued its series of professions-affecting decisions when it handed down *Arizona v Maricopa County Medical Association*. As one would expect of a Supreme Court decision, it generated a deluge of articles not just on substantive aspects of antitrust law but also on its implications for the health care field.

Courts dealing with antitrust/professions issues are beginning to cite *Maricopa* (which was a maximum price fixing case) for the proposition that conduct which restrains trade (other than price fixing) may yet be allowed if such conduct is premised on "public service or ethical norms."

For example, supposed anticompetitive restraints on medical staff access or on the scope of professional practice which foster "public service and ethical norms" may be able to withstand legal scrutiny. At the very least, claims premised on "public service and ethical norms" that are buttressed by substantiation most likely would result in group boycott conduct being taken out of the realm of *per se* and evaluated under the rule of reason giving a defendant a considerable litigation advantage.

Also, challenged conduct may pass muster if the basis for a restraint originates in the marketplace, i.e. "pulled" through the demand of the buying public rather than pushed by a supposed self-serving provider group. If the demand or preference for a particular kind of activity or practitioner category genuinely exists in the market, then a free enterprise response to that demand should not be penalized.

For example, the District Court for Western Pennsylvania in *Robinson v Magovern*, a medical staff privileges case, made much of the fact that Allegheny General Hospital, one of the defendants, had formulated objectives and a competitive strategy in response to a well-known management consulting firm's study con-

ducted well before the litigation at hand. In essence, the defendant hospital was able to prove that it wanted to be the best that it could be in providing a "true standard of excellence in patient care" based on achieving high-quality graduate medical education and research.

It is significant that the defendants in this case did not merely conclude that they know what is best for the consumer. Rather, they had an outside consultant research the needs of the marketplace in terms of consumer and referring physicians' perception. Then, they developed and implemented a competitive strategy that enabled the hospital to compete more effectively seeking to capitalize on those perceptions. The court ruled that the hospital's rejection of the plaintiff-doctor's staff application, based on input from its medical staff, was not "[inconsistent] with the hospital's institutional objectives or competitive strategy."

"Public service and ethical norms" and the enhancement of quality of health care are not merely abstractions or high-sounding opinions. They can be strived for, attained, and measured. The time to begin developing these kinds of working hypotheses and empirical data banks is now—not after a lawsuit is filed. Conclusory but unsubstantiated opinions claiming that one camp of health care providers either is superior or inferior to another are likely to be increasingly viewed with skepticism as the venting frustrations of those with a vested interest in preventing further encroachment upon their respective turfs. On a positive note, the courts are signaling that genuine concerns over who can practice or provide what kinds of medicine and health care under what terms and conditions will be accorded a fair hearing but only if supported by empirical substantiation and documentation. Legal precedent and marketing research articles in the literature point the way to conduct and accomplish such substantiation.

It appears that the courts are willing to meet the medical profession halfway concerning the tension resulting from a rapid infusion of competition into the marketplace on the one hand and legitimate interests in the provision of quality health care on the other. As to the latter, at least five court decisions in addition to a United States Supreme Court opinion signal a willingness to accept health care quality and ethics concerns as a defense to antitrust challenges if these concerns can be validated.

The key question in health care antitrust confrontations will be the nature of the conduct at issue. Anything short of price fixing, even group refusal to deal, most likely will be evaluated under the rule of reason standard if genuine concerns for public service, ethics, and quality of care can be established.

The medical profession stands to gain a great deal from a "public service and ethical norms" standard applied to health care trade restraint challenges. More reliance on marketing research and empirical substantiation complements this emerging standard. Careful documentation in this regard will be of assistance to hospitals and their medical staffs in evaluating credentials, approving applications, and delineating privileges.

*Dr. Trombetta is an attorney and marketing consultant for The Health Care Group, Bala Cynwyd, PA.

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MATERNAL DEATH

IN NEW JERSEY - 1983 ★

Thirteen maternal deaths were reported in New Jersey in 1983. All cases are summarized and suggestions made which may help to prevent such problems. Pulmonary embolism, cerebrovascular accident, and heart disease continue to be a significant cause of maternal death.

The Subcommittee on Maternal Mortality was established as a division of the Maternal and Child Care Committee of the Medical Society of New Jersey for the purpose of investigating all deaths of pregnant women in our state each year. The information gained is used to aid in an educational effort to prevent recurrences of preventable conditions. The Maternal and Child Health Program of the New Jersey Department of Health assists this Subcommittee by collecting data. This joint effort of Health Department personnel and a committee of MSNJ shows how public and private sectors of the health care team can work together to decrease maternal mortality.

RESULTS

There were 95,160 live births in New Jersey in 1983. Reports of 15 pregnant women who died were submitted to the Subcommittee for investigation.¹ In 1982, there were 20 maternal deaths reported.² The 1983 data are considered accurate because the present death certificate indicates whether the deceased was pregnant at the time of death. The members of the Subcommittee represent all areas of the state and are expected to know of any maternal death that occurred in their county that might not have been tabulated properly.

Table 1 lists the classification and mortality rates

using the reporting format suggested by the American College of Obstetricians and Gynecologists.³ The remaining statistical data are summarized in Tables 2 through 5.

A nonmaternal death is defined as the death of a gravid woman from causes not related to the pregnancy or its management. One of the two deaths in this category was due to esophageal leiomyoma. The second was the result of a fire. Twenty-three percent of the nonmaternal deaths in the past five years have been directly related to a fire. The duty of obstetricians and others to encourage the use of smoke alarms and escape plans in the event of a fire is to be stressed. As

*This article is the result of the work of the members of the Subcommittee on Maternal Mortality and the State Department of Health: James P. Thompson, M.D., Chairman; Jerald R. Cureton, M.D.; Joseph DeStefano, M.D.; Margaret Gregory, M.D.; William Hartko, M.D.; Michael Kreitzer, M.D.; Robert Malatesta, M.D.; Joseph Saladino, M.D.; Nicholas Salerno, M.D.; Makram Erian, M.D., Consultant; and Leah Ziskin, M.D., Consultant.

**Dr. Hansen is Associate Professor of Clinical Obstetrics and Gynecology and Director of the Obstetrical and Gynecology Clinic at UMDNJ-New Jersey Medical School. Dr. Noone is Chief, Division of Obstetrics at Our Lady of Lourdes Medical Center, Camden, and Assistant Clinical Professor of Obstetrics and Gynecology at Jefferson Medical College, Pennsylvania. Correspondence may be addressed to Dr. Hansen, Department of Obstetrics and Gynecology, UMDNJ, 100 Bergen Street, Newark, NJ 07103.

BY GERARD F. HANSEN, M.D., NEWARK**, THOMAS A. NOONE, M.D., CAMDEN**

TABLE 1

Classification and Mortality Rates

	Total Number
Live Births*	95,160
Maternal Deaths	15
Nonmaternal	2
Indirect	8
Direct	5

*Live births are events in New Jersey hospitals. Total births to New Jersey residents in 1983 exceeded this total because some women delivered out-of-state.

TABLE 2

Characteristics of Maternal Deaths by Race, Age, and Prenatal Care*

Race	Number	Percent
White	8	62
Other	5	38
Age		
Less than 20	2	15
20-34	7	54
35-39	1	8
Greater than 40	3	23
Antepartum Care		
None	4	31
Inadequate	1	8
Unknown	2	15
Adequate	6	46

*Nonmaternal deaths were excluded.

obstetrical and medical causes of maternal loss are addressed and reduced, an increasing effort must be made to decrease the societal causes such as fire, drug overdose, and auto accidents that presently account for almost 70 percent of nonmaternal deaths.

An indirect maternal death results from a previously existing disease or a disease that develops during pregnancy, labor, or the puerperium which is not directly due to obstetrical causes, but is aggravated by the physiological effects of pregnancy. There were eight such deaths, five of which were deemed nonpreventable by present-day standards of care. Three cases involved a cerebrovascular accident in which a proper standard of care was documented; one case of mitral valve prolapse and one case of tricuspid atresia were felt to be nonpreventable. The Subcommittee did feel that use of prophylactic antibiotics in a patient having an operative delivery who had a mitral valve prolapse or an artificial heart valve should be encouraged (Table 6).

A potentially preventable death in an antepartum patient with viral pneumonitis was studied. It was felt that earlier respiratory support, including a mechanical respirator if necessary, might have helped. One patient died at 35 weeks' gestation of cardiopulmonary arrest secondary to complications of mitral stenosis. She had congestive heart failure at 28 weeks' gestation for which she was hospitalized. If the patient had been

TABLE 3

Parity and Duration of Pregnancy

Parity	Number	Percent
0	5	38
1-3	6	46
4-6	2	16

Gestational Age

Less than 20 weeks	4	30
20-28	1	8
28-40	4	31
Over 40	4	31

TABLE 4

Classification and Preventability of Deaths

Nonmaternal Deaths	2
Maternal Deaths	13
Indirect Maternal Deaths	8
Nonpreventable	5
Preventable	3
Direct Maternal Death	5
Nonpreventable	1
Preventable	4
Physician Factor	4
Patient Factor	3*

*In one death, physician and patient shared preventability.

kept at bed rest in the hospital instead of being discharged in a week, she may have survived the pregnancy.

A third patient with diagnosed systemic lupus erythematosus was treated for pregnancy-induced hypertension. She developed cardiac failure postpartum and expired. Postmortem examination revealed that the direct cause of death was not a pulmonary embolism as had been initially suspected, but was myopericarditis. Use of steroids immediately postpartum might have prevented this death.

A direct maternal death is an obstetrical death usually from complications of the pregnancy, labor, or puerperium and from the intercessions, omissions, incorrect treatment, or a chain of events resulting from any of these complications.

An incident of necrotizing fasciitis involving an opportunistic infection of the episiotomy site with gram-positive and gram-negative organisms following a vaginal delivery was felt to be nonpreventable as the patient was observed closely and appropriate cultures and timely consultations were obtained. Even with hindsight, no therapy could be suggested that would have altered the course of this patient.

Three deaths due to pulmonary embolism were felt to be preventable. One patient traveled by plane from

TABLE 5

Causes of Death

1. Nonmaternal Deaths	2
Fire	1
Esophageal leiomyoma	1
2. Maternal Deaths	
A. Indirect	8
1. Nonpreventable	
Cerebrovascular accident	3
Heart disease	
Mitral valve prolapse	1
Tricuspid atresia	1
Systemic lupus erythematosus	1
2. Preventable	
Viral pneumonitis	1
Mitral stenosis	1
B. Direct	5
1. Nonpreventable	
Infection—necrotizing fasciitis	1
2. Preventable	
Pulmonary embolism	3
Preeclampsia with ruptured liver	1

Puerto Rico to New York three days after her delivery. She exhibited psychotic behavior with hallucinations and was admitted to a psychiatric unit. She was sedated and placed in body and extremity restraints for 48 hours. Enroute to the bathroom, she collapsed. Autopsy revealed massive pulmonary embolism originating from her legs causing immediate death in spite of resuscitation efforts. In retrospect, ambulation, with particular attention to calf movement, should have been done. If deep vein thrombus had been detectable, use of heparin would have been indicated.

A second patient died from a postoperative pulmonary embolism. She had elevated blood pressure and a dead fetus in utero; cesarean delivery was performed before her condition was stable.

The Subcommittee believes that pulmonary embolism following cesarean section is a preventable condition. Meticulous care and early ambulation, with use of antiemboli stockings, is critical.

The third death from pulmonary embolism occurred postoperatively in a 44-year-old patient who came to the emergency room with a complaint of shortness of breath. Signs and symptoms of pulmonary embolism such as arterial PO_2 of 62 and a "dusky" appearance, were ignored in favor of a diagnosis of hemorrhagic

shock secondary to a ruptured ectopic pregnancy. The patient was seven weeks pregnant at the time with an intrauterine gestation.

The fourth preventable maternal death was due to hemorrhage secondary to a ruptured liver. The patient had a severe form of gestational hypertension at 27 weeks for which she was treated on an ambulatory basis. Such a condition requires hospitalization, treatment with magnesium sulfate to prevent convulsions, fetal evaluation, and early delivery to prevent hepatic rupture with all its catastrophic consequences.

RECOMMENDATIONS

1. Endocarditis following uncomplicated vaginal delivery is extremely rare and does not require prophylactic antibiotics in many patients with underlying heart disease. However, since the patient with a prosthetic valve or mitral valve prolapse appears to be especially a high risk, it is recommended that patients with these conditions receive antibiotics when in labor. This empiric recommendation is based more upon concern than definite data. A modification of the guidelines of the American Heart Association is listed in Table 6.

2. The possible reluctance of obstetricians to ask for and follow the advice of anesthesiologists or pulmonary medicine specialists regarding mechanical ventilation support in a patient with respiratory difficulty should be overcome. In addition to helping to prevent atelectasis and respiratory acidosis, well-timed respiratory assistance decreases the work effort of a critically ill patient and may be lifesaving.

3. The obstetrician must remain the responsible caretaker of the pregnant woman. While appropriate consultation always is wise, it is the duty of the primary physician to coordinate the care of the patient. As complications become less frequent, even the most experienced obstetrician may not have the expertise necessary to handle certain problems. It would be wise for that physician to have available a list of consultants he would feel comfortable and confident in calling when a potentially serious situation requiring collaborative effort is encountered.

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TABLE 6

Antibiotic Regimen for Endocarditis Prophylaxis

Ampicillin 1.0 g IM or IV
Plus Gentamycin 1.5 mg/kg IM or IV
or if patient is allergic to penicillin:
Vancomycin 1.0 g IV over 30 minutes
Plus Gentamycin 1.5 mg/kg IM or IV

First dose when patient in labor—repeated Q 8 hours for 2 additional doses.

First dose when patient in labor—repeated Q 8 hours for 2 additional doses.

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DRG AND THE REGIONAL BLOOD CENTER

MERCY KURIYAN, M.D., AND NORMAN BOGGS, NEW BRUNSWICK*

The blood center that combines a reliable, efficient distribution system with reasonable processing costs, quality products, additional reference services, and benefits to meet patient/hospital needs in the region will enhance its ability to meet the challenge of DRG.

The current initiative to slow the growth of hospital costs is the Diagnosis Related Group (DRG) approach to case-mix reimbursement that has been under experimentation in New Jersey.¹ In 1980, the state began phasing in payment based on DRG for its acute-care hospitals.² Prospective payment demands that hospitals save money in order to make money, and turns the laboratory from a potential profit source to a cost center. With these new financial incentives, administrators and laboratory management are taking a closer look at cost containment.³

When a hospital is committed to DRG reimbursement, its major goal must be to deliver care at the lowest possible cost. The hospital cannot collect on cost over-runs, but is allowed to retain the difference between the DRG reimbursement and the amount expended. Cost curtailment is the key to survival under a system where reimbursement is predetermined by agencies outside of the institution itself.

The institution which contrives the shortest patient stays, the smallest number of tests and procedures, and the minimum of essential services is rewarded. The theory, of course, is that efficient management can deliver health care at a predetermined cost without harmful curtailments. Some hospitals have misgivings and believe that the theory may not work quite that way. What positive responses can be planned? What are the negative effects?

New Jersey Blood Services, a division of the Greater New York Blood Program, serves as a regional blood center to 65 hospitals in central and northern New Jersey. Close monitoring of the trends that result from the hospital DRG program and their possible effect on the blood center over a period of four years has been assessed. The areas of particular interest are the demand for blood and blood products, cost of blood under the DRG, effect on blood center receivables, hospital donor recruitment, and the impact of hospital cost containment on the future direction of blood center operations.

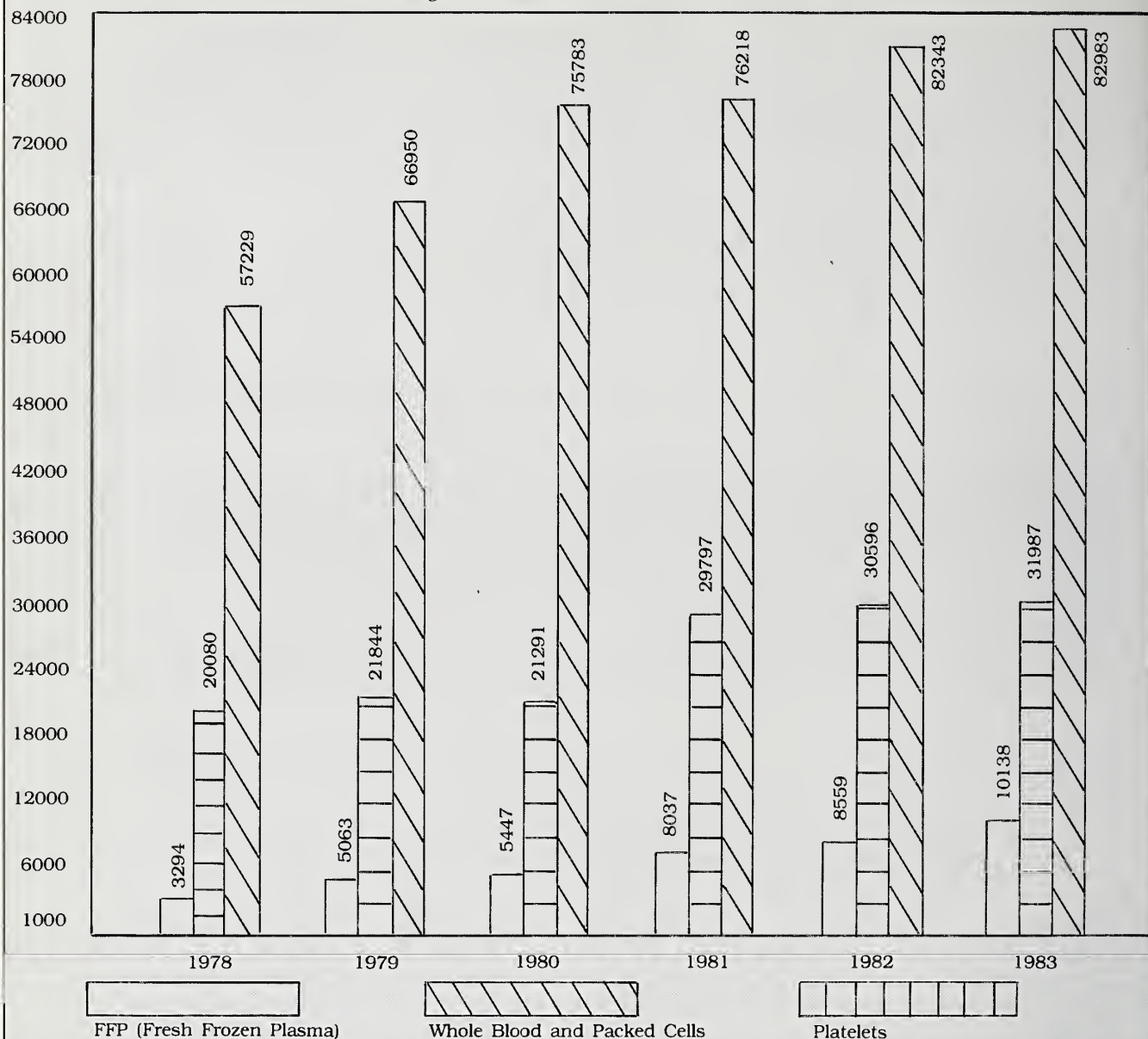
BLOOD CENTER FUNCTIONS

Blood center functions in areas of production and distribution continue to grow. A negative impact on the demand for blood or products cannot be demonstrated (Table 1). In fiscal year 1983 to 1984, from collections, 116,024 products for direct transfusion were prepared, representing a 12 percent increase over the previous year. Laboratory production of packed cells increased 22 percent, platelets 35 percent, and fresh frozen plasma 49 percent over the previous year. Hospitals received 135,006 blood products for transfusion, representing an 8.7 percent increase over the

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TABLE 1

New Jersey Blood Services—Distribution 1978 to 1983



previous year. Distribution of packed cells increased 25 percent, platelets 15 percent, fresh frozen plasma 13 percent, and cryoprecipitate 48 percent over the previous year. A decrease in collections partly was attributed to fear of acquired immunodeficiency syndrome (AIDS).

Cost of Blood Under DRG. Under DRG, the blood "processing cost" billed by hospitals at the time of their integration into the system became part of the relevant DRGs. While New Jersey Blue Cross still required hospitals to bill the processing cost under "trailer billing," the charge becomes part of the DRG unless the patient's Blue Cross does not cover blood processing, which happens rarely. On the other hand, the DRG specifically allows hospitals to charge for a "blood cost" (nonreplacement fee). Thus, it could become profitable for a hospital to retain a nonreplacement fee.

The Nonreplacement Fee. This charge has been deliberately left out of the DRG by state regulations. Hence, it can become a source of extra hospital cash.

Furthermore, since DRGs were based upon stated processing costs that then were too low, many hospitals could not get by if they did not maintain the "blood cost" or nonreplacement fee. In some cases, hospitals had a processing cost as opposed to a blood cost—which was too low. The processing cost did not, in fact, cover the cost of blood purchased from blood banks. DRGs were calculated on actual costs for 1978 and 1979.

The language of the state regulation⁴ covering DRG is enlightening: "In order to encourage hospital solicitation of blood donations, the purchase cost of whole blood and the equivalent of blood extender and/or plasma are excluded. ..." We have found no hospital which interprets this language to exclude the processing cost; New Jersey Blue Cross does not interpret it this way, nor, as far as can be ascertained, does the State Department of Health. On the other hand, "blood costs," i.e. nonreplacement fees, are excluded and may be and are charged to patients unless a so-called

TABLE 2
Survey of New Jersey Hospitals (34)—Centralized Blood Center Services

Hospitals Beds	Under 200	200-300	300-400	400 & over	Total
<i>No. of Hospitals</i>	10	5	9	10	34
<i>Crossmatches Annually:</i>					
Less than 1,000	4	-	1	1	6
1,000 to 5,000	6	3	1	-	10
5,000 to 10,000	-	2	3	2	7
10,000 or more	-	-	2	6	8
<i>Washed Cells Needed from Center</i>	9	3	6	4	22
<i>Has Cell Washer</i>	1	2	2	5	10
<i>Reference Laboratory Center Services</i>	9	3	6	8	26
<i>Antibody Panel Workup:</i>					
Yes	8	4	8	9	29
No	2	1	-	1	4
<i>Crossmatch Services from Center:</i>					
Problem Compatible Units	10	5	8	9	32
Elective Surgery	10	3	5	5	23
All Crossmatches	2	-	-	-	2

"credit" is received. Credit is written evidence that the patient or family has donated blood in the recent past.

Apparently the State Office responsible for the DRG feels that blood is just one of many complex items consumed by hospitals and it does not want to be involved in the nonreplacement fee controversy beyond allowing the fee where it exists.

Since the inception of the DRG, two hospitals have reinstated the nonreplacement fee in the first instance, perhaps as an aid in recruiting donors. Secondly, in part, hospital administration had a degree of uncertainty where blood charges were concerned. It is doubtful that hospitals who do so would stop charging a nonreplacement fee at this time when any source of extra cash over and above the DRG is so precious, even though the brunt of this fee is born by the largest users of blood, the aged.

Blood Center Receivables. In order to impose the DRG on hospitals, the state of New Jersey had first to deal with the back debts of inner-city hospitals having a high percentage of welfare patients. They did this by a one-time, so-called, "infusion of cash." Blood programs benefited from this improved cash position. Hospitals paid up their back bills. Hence, the DRG has substantially reduced blood center receivables.

On the other hand, hospitals in more affluent areas now were faced with restrictions under which they no longer could charge their affluent patients all that the traffic would bear, so as to subsidize other aspects of their operations. One such hospital now is struggling with a huge deficit due to DRG and actively is reducing staff and services. The result has been a frantic search for areas where costs can be reduced. One such area might be the cost of blood purchased from outside blood programs. The following question is asked by

some administrators: Can bleeding donors become a saving?

Hospital Donor Recruitment. Because of the increasing processing costs charged by voluntary blood programs, it may be possible for some hospitals to bleed donors at a lower cost than that charged by their blood center. The question remains: Can hospitals recruit the donors on a large scale, economically, and meet all their needs?

In 1982, donations directly to New Jersey hospitals increased about 3.7 percent. This increase in hospital donations—only the second in nine years—did not reverse a downward trend. Under the DRG, some hospitals believe it is profitable to increase their recruitment of donors. However, as a general trend, there was a decrease in hospital collections by 10 percent in 1983.

Impact of Hospital Costs Containment. Because of the financial pinch resulting from the DRG, hospitals seriously have been considering various expedients by which expenses can be reduced and cash income can be generated outside of the DRG. First among these strategies are mergers.⁵ Mergers are contemplated and develop between hospitals and/or between hospital blood banks. Mergers lead to joint purchasing from suppliers who charge the lowest price; this affects the blood center distribution and transportation systems. Another effect is joint blood donor recruitment and development of hospital blood donor centers in competition with the local blood center. Inner-city hospitals may construct satellite facilities in suburban areas where patients are more affluent and payment is more prompt. Satellite facilities can concentrate on procedures that are not covered by the DRG and therefore are not regulated in price. These facilities have explored the use of blood products on their premises,

TABLE 3

Centralized Services from Blood Centers to Hospitals for Cost Containment

1. Autologous transfusion
2. Therapeutic phlebotomy
3. Pheresis programs
4. Reference laboratory
5. Tissue typing
6. Crossmatching services
7. Coagulation laboratory
8. Frozen and washed blood
9. Pretransfusion testing
10. Cytomegalovirus antibody negative, HbS negative & irradiated blood for neonates
11. Continuing education programs

but transfusions still are being given in hospitals.

It is far too soon to speculate what changes, if any, might accrue to blood programs under such contingencies. Much depends upon the blood supply. The bottom line might be: Who can supply the safest blood at the lowest price? As certain hospitals become larger, through mergers, and better equipped to process blood in many ways, a blood center may come to be regarded by certain hospitals as an enterprise which just recruits and bleeds donors. On the other hand, some sort of joint venture arrangement between the hospital and blood center may occur. Under the principle of "unbundling," blood centers might become more diverse and provide centralized testing such as crossmatching and patient blood bank testing.

This particularly would be useful to medium-sized and smaller hospitals in more rural areas, who experience somewhat contrary problems. Their blood banking establishments are less complex and less well equipped, so they may find themselves increasingly dependent upon a regional blood bank that can furnish a growing number of specialized services. A recent survey seems to show that such hospitals are considering an outside source for specialized blood bank tests (Table 2).

As pressure to cut expenses increases and medical advances demand more technical support, smaller hospitals increasingly may need to contract-out tests and other procedures.

BLOOD CENTER PLANNING STRATEGIES

Blood programs might well be advised to anticipate changes by preplanning, where they believe they can render the service less expensively. Certain specific services already are surfacing that are worthy of more careful study (Table 3).

Reference Laboratory. Due to the specialized nature and the time consumed in the identification of unknown antibodies, problem cases are referred to a centralized reference laboratory usually at the regional blood center. These services may be expanded to identification of nonproblematic antibodies also. Many smaller hospitals do not have the necessary staff and

reagents tend to expire since antibody problems occur infrequently. Selection of compatible units and crossmatching services are attractive under cost-containment when combined with the economics of large-scale testing.

Pheresis, Frozen and Washed Cells. Within the past three years, in response to hospital demand, new services initiated by ARC/New Jersey Blood Services include washed red blood cells, cytomegalovirus antibody negative and hemoglobin S negative red cells for neonates, reference laboratory services, and screening for blood units negative for specific antigens (Table 3).

Distribution. Under the DRG system, any unusual costs, such as dispatching cabs for emergency product, or even sending a hospital vehicle, cannot be charged to individual patients. A blood center with an effective system of planned, computerized deliveries can save hospitals money and personnel time. A good distribution system and reliable emergency transportation can become another fringe benefit for the hospital.

Over the course of the three years, a system of planned blood delivery was instituted to the majority of hospitals we service. This ensures the availability of an adequate hospital blood inventory to meet routine needs, except in times of blood shortages. This system has been computerized and currently is being expanded to include all hospitals. A willingness to change with circumstances is part and parcel of a need to adapt to current trends.

Educational Activities. One of the areas subject to curtailment for lack of funding in hospitals under the DRG may be educational facilities. A blood center which can offer such opportunities will be of value to many hospitals. Expanded educational programs, such as seminars, blood bank review courses, technical newsletters, tapes, lectures, videos and slides on various topics have been enthusiastically received from this blood center by New Jersey hospitals, with the demand continuing to increase.

While educational facilities and a reference laboratory might be considered fringe benefits, they certainly become a part of what a price offers in a market restrained by the DRG.

CONCLUSION

The hospitals will argue that the blood suppliers should be subject to the same pressures and curtailments as they are under the DRG system. The blood center that combines a reliable, efficient distribution system with reasonable processing costs, quality products, additional reference services, and benefits to meet the patient/hospital needs in the region would be using a timely approach to changing trends.

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REPLACEMENT OF LACERATED SUPERIOR VENA CAVA WITH SYNTHETIC GRAFT

ANDREW S. OLEARCHYK, M.D., CAMDEN*

A patient suffered extensive laceration of superior vena cava and the innominate vein due to sternal retraction during coronary artery bypass grafting. Both vessels were replaced successfully with a synthetic graft. Careful sternal retraction should avoid injury to innominate-caval venous system.

Median sternotomy, introduced by Milton in 1897,¹ is an excellent incision for cardiac and great vessel operations as well as other thoracic procedures. One should realize this incision may cause devastating complications including tears, lacerations or avulsions of the innominate vein, and multiple sternal or rib fractures.^{2,4} Excessive sternal retraction also may injure the brachial plexus. Repeated sternotomy can lead to major cardiac and aortic laceration and injury to coronary arteries, saphenous vein, or internal mammary grafts.² Postoperative sternal instability, dehiscence, or infection with serious or even fatal mediastinitis also may occur.

CASE REPORT

A 63-year-old woman, 65 cm tall and weighing 73 kg, was admitted to the coronary care unit on May 13, 1984, with crushing retrosternal pain, diaphoresis, and dyspnea at rest. She had unstable angina for several months but refused hospitalization. Electrocardiogram revealed changing T waves anterolaterally and new onset of atrial fibrillation. She was treated with nitrates, calcium channel blockers, digitalis, and diuretics. Acute myocardial infarction was excluded by serial electrocardiograms and cardiac isoenzymes, but she responded poorly and continued to have chest pain at rest.

Cardiac catheterization and coronary angiography on May 22, 1984, disclosed more than 75 percent stenosis of the proximal left anterior descending, circumflex, and right coronary arteries with no collaterals. During the procedure, she had several episodes of excruciating chest pain, despite intravenous nitroglycerine infusion. An intra-aortic balloon, inserted through the right common femoral artery, resulted in acute ischemia of the leg.

The patient was taken to the operating room on May 23, 1984, for emergency coronary artery bypass graft. Median sternotomy was performed and retraction was accomplished using the Ankenney retractor. Aortic, single right atrial cannulation, and left ventricular venting via the right superior pulmonary vein proceeded smoothly. We began cardiopulmonary bypass at a flow rate of 2.2 l/min/m²/BSA with a moderate systemic hypothermia, cold potassium cardioplegia, and an ice slush topical myocardial protection.

Additional sternal retraction, needed to expose the circumflex obtuse marginal artery, resulted in a com-

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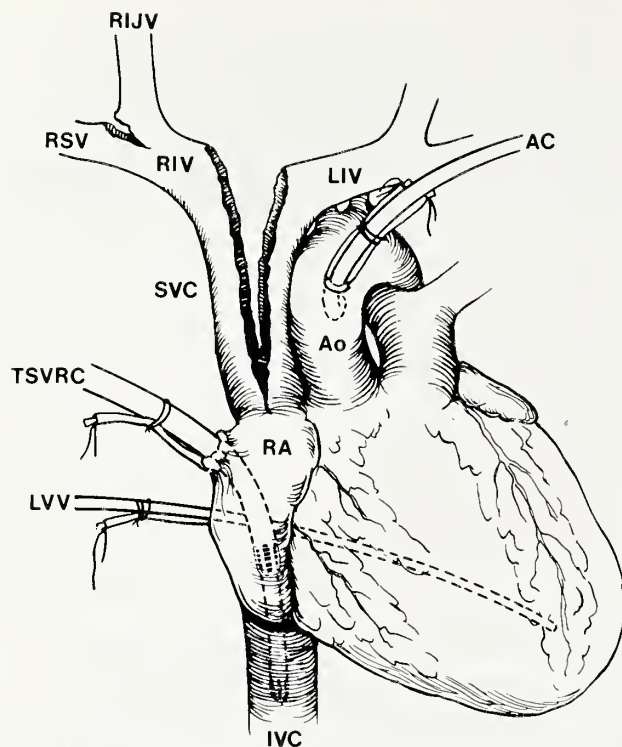


Figure 1—Complete longitudinal laceration of the SVC, avulsion of the left innominate and right subclavian veins from sternal retraction during exposure of the circumflex obtuse marginal artery for grafting. Ao, aorta; SVC, superior vena cava; RA, right atrium; IVC, inferior vena cava; RIV, right innominate vein; LIV, left innominate vein; RSV, right subclavian vein; RIJV, right internal jugular vein; AC, aortic canula; TSVRC, two stage venous return catheter; LVV, left ventricular vent.

plete longitudinal laceration of the superior vena cava and avulsion of the left innominate and right subclavian veins causing profuse venous bleeding (Figure 1). Deep hypothermia was instituted and the lacerated great veins were exposed while lost blood was replaced by cardiectomy suction. We removed the Swan-Ganz catheter, controlled the bleeding by applying vascular clamps to the superior vena cava-atrial junction and left innominate vein, and ligated the right subclavian vein. The blood from the right internal jugular vein initially was drained through cardiectomy suction to avoid sudden fatal venous engorgement of the head and neck. We cannulated the right common jugular vein and recannulated the inferior vena cava for a double venous return (Figure 2).

Venous graftings to the circumflex obtuse marginal, left anterior descending, and right coronary arteries were carried out with an aortic cross clamp time of 29 minutes.

The superior vena cava was replaced by interposition in a reverse fashion of the 20 x 10 mm bifurcated polytetrafluoroethylene (PTFE) graft. We ligated the left arm of the graft and anastomosed the right to the right internal jugular vein in end-to-end fashion. The vertical 20 mm portion of the graft was sewn to the remnant of the superior vena cava at the atrial junction also in end-to-end fashion. We replaced the left innominate vein by a 10 mm PTFE graft which was anastomosed to the proximal remnant of the vein in end-to-end fashion and to the side of the vertical por-

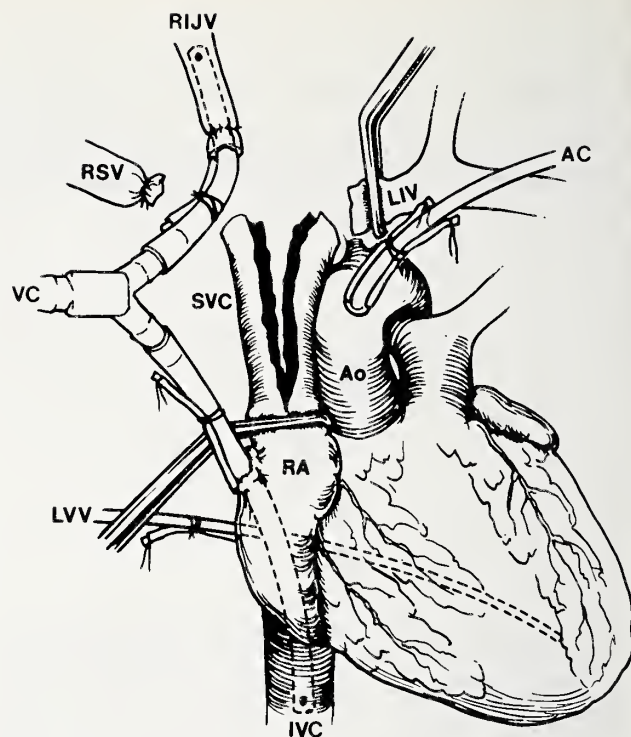


Figure 2—Control of bleeding from laceration-avulsion of the innominate-caval venous system by the application of vascular clamps to the SVC-atrial junction and the left innominate vein, ligation of the right subclavian vein and double cannulation of the right internal jugular vein and the IVC. Ao, aorta; SVC, superior vena cava; RA, right atrium; IVC, inferior vena cava; LIV, left innominate vein; RSV, right subclavian vein; RIJV, right internal jugular vein; AC, aortic canula; VC, venous canula; LVV, left ventricular vent.

tion of the graft (Figure 3). The other option considered was to shorten the vertical part of the PTFE graft and anastomose its left arm to the left innominate vein. The patient then was rewarmed and weaned from cardiopulmonary bypass (3 hours, 28 minutes) without difficulty, and the intra-aortic balloon was removed. The estimated blood loss was three liters.

Postoperatively, head and neck swelling and echymosis disappeared within a few days. The single remaining problem was chronic leg ischemia due to occlusion of the right external iliac artery (intra-aortic balloon site) for which she underwent femoro-femoral bypass, using 10 mm woven Dacron® graft two months later.

Dynamic flow studies and static images were obtained on July 31, 1984, during the injection of 20 μ Ci Tc 99m pertechnetate into the right external jugular vein (Figure 4) and the cephalic vein (Figure 5). They revealed patent and functioning grafts replacing the superior vena cava and the left innominate vein. The venous blood was returning promptly to the right atrium. The patient was doing well at the 12 months' followup.

DISCUSSION

Separation of the two halves of the sternum by a retractor spreads apart both innominate veins with a maximum tension exerted at their junction with the superior vena cava.³ If excessive retraction continues, it may injure the innominate-caval venous junction.

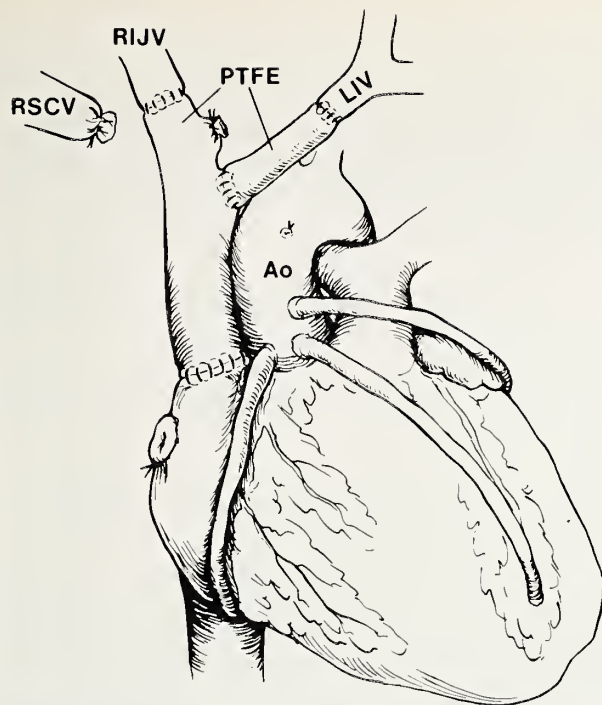


Figure 3—Replaced SVC by interposition in a reverse fashion of the 20 x 10 mm PTFE graft and replaced left innominate vein by 10 mm PTFE graft. A complete coronary artery bypass grafting also is shown. Ao, aorta; LIV, left innominate vein; RSCV, right subclavian vein; RIJV, right internal jugular vein; PTFE, polytetrafluoroethylene graft.

This may range from a simple tear of the innominate vein or its avulsion to an extensive laceration of the superior vena cava.

To prevent this, sternal retraction must be slow, not more than one to two cranks at a time, with constant attention to the innominate vein. One should avoid retraction after cannulation (since visualization of the vein is obscured by an arterial catheter) and also during cardiopulmonary bypass when the innominate vein is underfilled.

Additional length of the innominate vein may be obtained by the division of perivenous ligamentous attachments and major venous tributaries.⁴ If further exposure is needed for the ascending aorta or its arch, the left innominate vein should be ligated close to its junction with the right innominate vein.⁴ Draining of the left innominate vein through the inferior thyroid and left highest intercostal veins prevents the development of venous stasis in the head and neck. Obviously, both innominate veins should not be divided.

Once an injury has occurred, the hemorrhage should be controlled by digital compression and the lost blood reused.* Next, one should cannulate the patient to institute cardiopulmonary bypass and, in extensive lacerations, to administer deep or profound hypothermia. In simple tears, the area of an injury and, in extensive lacerations, the entire innominate-caval venous system should be dissected and exposed for the safe application of vascular clamps, ligation, or repair.

A simple laceration of the innominate vein may be oversewn, but avulsion of the innominate vein necessitates ligation and patch angioplasty of the superior



Figure 4—Static image during injection of 20 μ Ci of Tc 99m pertechnetate into the right external jugular vein shows patent reversed bifurcated 20 x 10 mm PTFE graft replacing the SVC. The venous blood flows promptly into the right atrium, ventricle, and pulmonary artery.



Figure 5—Static image during injection of 20 μ Ci of Tc 99m pertechnetate into the left cephalic vein demonstrates a patent 10 mm PTFE graft which replaced the left innominate vein.

vena cava under partial occlusion clamp.^{3,5} The avulsion site of the superior vena cava should not be closed by a lateral suture for fear of inevitable constriction which may cause venous hypertension above.

During the application of occluding clamps, care must be taken to avoid clamping across the central venous catheter or Swan-Ganz catheter since additional crushing may ensue or complete hemostasis may be prevented. One also should make sure that these catheters are not incorporated into the suture line during the repair.

Extensive avulsions and lacerations may require considerable dissections, separate cannulation of the right innominate or internal jugular veins, and deep or profound hypothermia. Repair should be with venous or synthetic patch angioplasty.

If direct repair or patch angioplasty are not feasible, then the only alternative is partial or complete replace-

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ment of the superior vena cava and of the innominate vein.

At present, the only available vena cava substitutes with acceptable short- and long-term patency rates are spiral vein grafts^{6,7} and unsupported PTFE graft* or externally stented PTFE graft.^{8-12†}

Spiral vein bypass provides an effective treatment of fibrosing mediastinitis and malignancy with immediate and long-term relief of the superior vena cava syndrome.⁶ Anderson and Li successfully replaced a segment of the superior vena cava involved by leiomyosarcoma with a spiral vein graft.⁷ However, preparation of this graft is time consuming and not practical for emergency replacement of the great veins.

A preferable substitute for the vena cava in emergency situations is PTFE grafts which are relatively inert, nonwetttable synthetic polymer with electro-negative pores that impede thrombosis.^{9,10} PTFE grafts have short-term (30 days) patency rates from 75 to 100 percent and long-term (3 to 22 months, averaging 9.7 months) patency rates of 66.5 percent in dogs.^{9,10}

Clinically, PTFE grafts were used by Osada et al.¹¹ to replace the superior vena cava and innominate vein involved by a primary mediastinal seminoma and by Katz et al.¹² who reconstructed the inferior vena cava after resection for hypernephroma of the right kidney. In the former case, graft patency was demonstrated by superior vena cavogram 20 months after the operation. In the later case, graft patency was shown by radionuclide inferior vena cavogram six weeks after the operation.

Patency rates of synthetic grafts in the thoracic vena cava are higher as compared to those in the intra-abdominal vena cava due to higher flow and less external compression in the former.⁸

The case presented appears to be the first in which the superior vena cava and innominate vein were replaced successfully in emergency circumstances. The

left innominate vein was reconstructed, instead of being ligated, to avoid any possibility of venous stasis in the head and neck. In our patient, the grafts remain patent and functioning, as assessed by radionuclide superior vena cavogram at two months and by clinical evaluation at the 12 months' followup.

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THE FAMILY GENOGRAM: AN UNDERUTILIZED CLINICAL TOOL

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Only one of eight surveyed family physicians currently use family genograms. Three out of four patients were able to complete self-administered genogram forms in the waiting room before seeing the physician. Further development of self-administered genogram forms appears warranted.

The issues addressed in this paper were raised after considering that a thorough family history is important in clinical care and the family genogram is a useful tool for organizing such information. Family information is useful for:

1. Diagnosing familial biological diseases such as distal renal tubular acidosis, hypercholesterolemia, breast cancer, multiple polyposis, cystic fibrosis, hemophilia, allergy, and diabetes.^{1,2}

2. Diagnosing familial psychiatric disorders such as bipolar affective disorder, schizophrenia, and suicide.^{3,4}

3. Identifying potentially deleterious family constellations such as stepfamilies, divorce, and death of a spouse.^{5,6}

4. Detecting such problems in the family as violence and addiction.^{7,8}

5. Evaluating somatic complaints.^{9,10}

6. Understanding the family's role in the etiology of illnesses such as diabetic ketoacidosis, acute asthma attacks, streptococcal pharyngitis, and respiratory tract infections.¹¹⁻¹³

7. Developing and implementing management plans.^{14,15}

The family genogram is an attractive clinical tool for organizing the information which is important in these clinical situations. Physicians have a general familiarity with family genograms or pedigrees from

their use in genetics and can obtain complete family histories after receiving brief, specific instructions about the use of genograms.¹⁶ The graphic format of the genogram allows quick and accurate retrieval of family information¹⁶ and allows a physician to easily update the family information as new information is obtained.

The foundation of a genogram is the family pedigree which graphically displays the structure of the family, i.e. who is in the family and how they are related to one another. Additional information is added to this framework depending upon the specific interests of the clinician. If the family genogram is being constructed in a "review of systems" manner during an initial encounter with a patient, the clinician may record basic demographic information about each family member, e.g. dates of birth/death, education, occupation, ethnicity, and may note who has major health problems such as hypertension, diabetes, cancer, or alcoholism. During this initial visit, the physician also may identify the members of the patient's current household and symbolize the more critical relationships among the family members (Figure 1).

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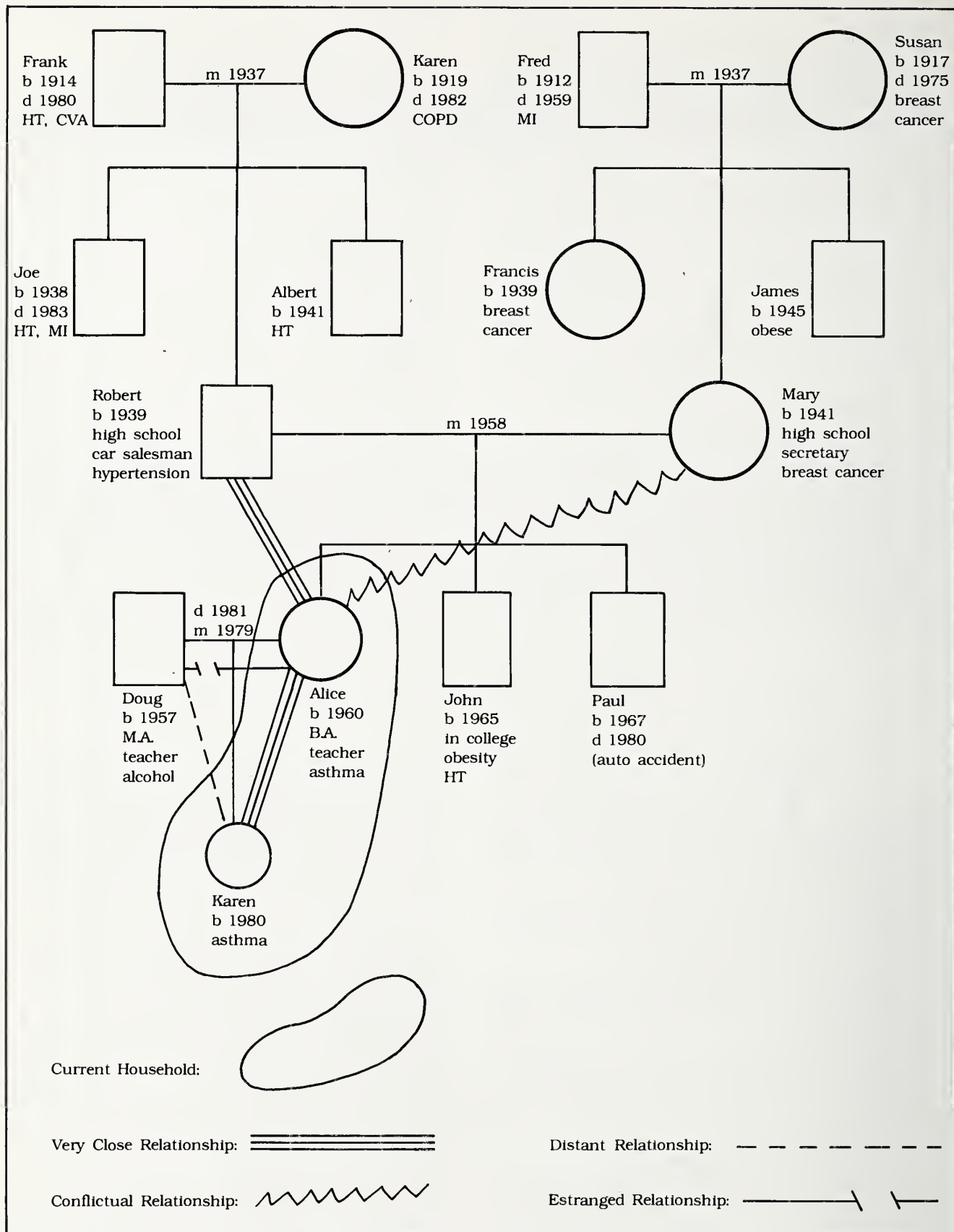


Figure 1—An example of a family genogram.

During subsequent encounters with the patient or other family members, the physician may need to obtain additional family information as part of the history of the present illness in order to evaluate the patient's presenting complaint or to develop and im-

plement a management plan. The graphic format of the genogram allows both quick review of the family information obtained during previous encounters and addition of new information obtained during the current encounter. Narrative descriptions containing the same

information may be scattered throughout the medical record precluding the development of a coherent picture of the family. This may prove especially difficult for a physician who has not had a continuing relationship with the patient or family.

Although the genogram may be an attractive method of organizing family information which is gathered at different points in time, its promotion as a relevant clinical tool presumes: 1) that family physicians consider family information important enough to the care of their patients to obtain "review of systems" family histories from new patients; 2) that the family genogram currently is underutilized in clinical care; and 3) that family physicians are favorably inclined toward the family genogram as a clinical tool. A survey of family physicians was conducted to determine whether there is empirical support for these presumptions.

SURVEY METHODS

A survey which obtains physicians' self-report of their usual approach to specific clinical situations has limitations, especially in regard to a response bias which may reflect the investigators' agenda. This potential bias may lead to questions about the validity of the survey results. Despite this hazard, the survey method was chosen as the first step in studying this area with an understanding that other research methods may need to be employed in the future to corroborate the survey results.

All board certified family physicians in New Jersey were mailed an anonymous questionnaire which collected background information such as percentage distribution of professional time and medical school affiliation. The survey instrument included questions about the physicians' current approaches to obtaining family histories from new patients. It also obtained

information about the relative importance of different types of family information in clinical care and the acceptability of the genogram as a tool for organizing family information.

SURVEY RESULTS

One hundred eleven physicians responded to the survey for a return rate of 35 percent. Of these physicians, 82 percent spend greater than 75 percent of their professional time seeing patients, while 6.3 percent are full-time and 6.3 percent are part-time faculty members; 47 percent are clinical faculty members or preceptors. Similar information on nonresponders is not available for comparison, so the representativeness of the responding physicians is unknown.

In regard to the physicians' current approaches to obtaining a family history, 47 percent of the surveyed physicians always take a family history when seeing a new patient; 30 percent usually take a history; 20 percent sometimes take a history; and 3 percent never take a family history. Sixty-six percent of the surveyed physicians use only one method to take a family history which usually is an informal interview prior to the physical examination (Table). When all of the responding physicians are considered, the informal interview prior to the physical examination still is the most frequently employed method. Only 11.7 percent of the family physicians use the family genogram, and it almost always is used in combination with another method.

The time spent obtaining a family history from a new patient ranges from 1 to 30 minutes with an average of 5.6 minutes. Many of the responses commented that the amount of physician time spent on taking the history depends on the individual case, and that extra time is spent if it is necessary. Seventeen percent of the physicians only inquire about medical information

TABLE
Current Methods of Obtaining Family History

Method	Physicians Using Only One Method N = 73		All Physicians Surveyed* N = 111	
	N	%	N	%
Informal interview by physician prior to physical examination	60	82.2	94	84.7
Form completed by patient and reviewed by physician	9	12.3	34	30.6
Form completed by patient, not reviewed by physician, but filed in medical record	1	1.4	6	5.4
Interview by someone other than physician, e.g. office staff or nurse	1	1.4	14	12.6
Genogram completed by physician during interview with patient	1	1.4	8	7.2
Genogram completed by patient before seeing physician	0	0.0	5	4.5
Family circle completed by patient	1	1.4	5	4.5

*Includes the 38 family physicians who use more than one method to obtain family history from new patients.

Narrative

Alice is a 25-year-old teacher with a B.A. degree who lives with her daughter, Karen age 5. Alice and her husband, Doug, were divorced in 1981 after two years of marriage. Alice has one brother, John, age 19, who is attending college, and her second brother, Paul, died at age 13 in 1980 in an accident. Both of Alice's parents are alive, and they have been married since 1958. Her father, Robert, is 45 years old, completed high school and works as a car salesman. Her mother, Mary, is 43 years old, completed high school and works as a secretary.

Genogram

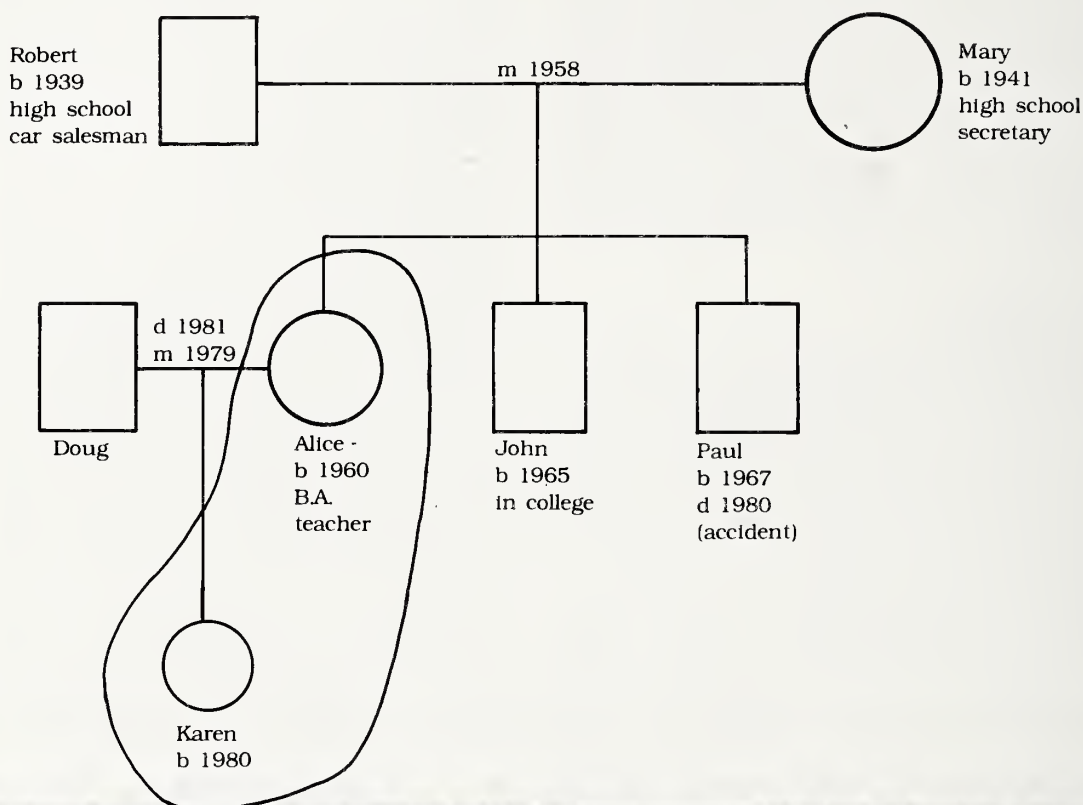


Figure 2—An example of narrative and genogram family history.

when gathering a family history, but when both medical and psychosocial information are included in the history, an average of 25 percent of the interview is spent on psychosocial history and 75 percent on medical history.

The physicians were asked to rank the following types of family information in order of importance to them in treating their patients (1 = most important, 5 = least important): demographic information (e.g. birth dates, physical location, educational level, marital status); medical information (e.g. diseases, injuries, disabilities); social information, (e.g. household size or membership, career and financial status, marriage and family status or plans); social problems within the family, (e.g. alcoholism, drug abuse, chronic unemployment, mental illness); and family dynamics, (e.g. closeness/conflict in relationships, interaction patterns). When the results were averaged, medical information was most important with an average rank of 1.4; social problems followed with an average ranking of 2.3; social information was ranked 2.9; and family dynamics was ranked 3.1. Demographic data was thought to be the least important with an average rank of 4.1.

The questionnaire also included the same family history written in two ways, one as a narrative and one

in a genogram format (Figure 2). The physicians were asked which method they would prefer for recording family information, and which method they would prefer for reviewing or retrieving family information. Fifty-three percent preferred the genogram over the narrative as a recording method, and 76 percent preferred the genogram for reviewing or retrieving information about the family. It should be noted that the physicians' reported preference for the genogram was not obtained after they had extensive experience with both the genogram and the narrative methods. After practical experience with the two methods, their opinions may be different from those reported here.

DISCUSSION

Any discussion of the results of this survey must be predicated by a consideration of how they may be biased by the less than 100 percent response rate and the questionnaire's reflection of the investigators' obvious bias toward complete family histories and family genograms. Due to these two factors, this survey may overestimate how often family physicians obtain family histories from new patients and how many physicians use family genograms. This survey also may overestimate family physicians' favorable attitudes toward the genogram as a useful tool for recording and review-

ing or retrieving family information.

This survey was conducted to determine whether the presumptions underlying the promotion of the family genogram as a relevant clinical tool are accurate. The first presumption, that family physicians obtain "review of systems" family histories from new patients, is supported in that over three-fourths of the surveyed family physicians usually or always do so and that only 3 percent never do so. Furthermore, a variety of types of family information appear to be important to the physicians, since five out of six of the family physicians include both medical and psychosocial information in their family histories. The family genogram easily accommodates the recording of several types of information, especially the medical and social information which the physicians ranked as the most important family information for the care of their patients.

The second presumption was that the family genogram currently is underutilized in patient care. Since only one in eight family physicians uses a genogram for history taking, this presumption is supported. There probably are two major explanations for this observation: The physicians may not have training or experience in the use of genograms and they may not have the time that is required for obtaining the information needed to construct family genograms. The latter explanation is supported by the observation that constructing complete genograms through personal interviews takes approximately 15 to 20 minutes,^{16,17} and the finding of this study that physicians spend approximately 6 minutes on taking family histories. If one's goal is to increase the use of genograms in practice, then training for physicians may be necessary but, more importantly, methods of obtaining genograms that require less physician time may need to be developed and evaluated, e.g., self-administered genograms.

The final presumption underlying the promotion of the genogram is that family physicians are inclined favorably toward the family genogram as a clinical tool. In this survey, 53 percent of the family physicians reportedly prefer the genogram method over the narrative method for recording family history information, and 76 percent prefer the genogram for reviewing or retrieving family information. Although family physicians currently are not using family genograms, they may be willing to use this tool in their clinical work if a feasible protocol is developed.

A self-administered genogram protocol may be acceptable to family physicians and may be able to overcome barriers to the use of genograms in practice. In this protocol, a patient completes a three- or four-generation genogram, including demographic and family interaction information, prior to seeing the physician. The physician then interviews the patient to obtain medical and social information. This protocol gathers different types of family information but limits the physicians' inquiry to the types of information they consider the most important for patient care. The protocol also allows flexibility in history taking in that the entire history could be obtained at one visit or collected over two or more visits.

Although a self-administered genogram protocol may be useful from the physicians' point of view, questions from the patients' point of view arise: Can pa-

tients complete self-administered genograms in the waiting room before seeing the physician? Does providing a patient with either a blank page or a three-generation skeleton affect his ability to complete his genogram? How do patients respond to the self-administered genogram? The following pilot study was conducted to address these questions and to determine whether continued development is warranted.

SELF-ADMINISTERED GENOGRAM METHODS

The subjects of the study were adults (over 18 years of age) visiting the model unit of a Family Practice Residency Program. Since the study was evaluating the self-administered genogram packets, there were no selection criteria for the subjects such as a first or return visit, family composition, marital status, or presenting problem. Patients were selected for the study as they entered the office and registered for their visit to provide a convenience sample for this pilot study. All potential participants were invited to participate at which time the study was explained.

After informed consent was obtained, the patients were given the self-administered genogram protocol and were asked to try to complete the genogram as they would like it to appear in their medical record, before being seen by the physician. Half of the patients received a three-generation skeleton genogram, and the other half received a blank recording page. The amount of time required to complete the genogram was recorded, and a brief interview followed their completion of the genogram.

During the followup interview, the information on the genogram was reviewed to identify errors or omissions. The difficulty of completing the protocol was rated on a scale of 1 for easy, 2 for somewhat difficult, 3 for moderately difficult, and 4 for very difficult. This question was deliberately focused on difficulties with the protocol in order to maximize critical feedback from the patients, so that the protocol could be improved on the basis of this pilot project. Individuals also were asked if they were able to complete their genogram before seeing the physician and for their perception of the impact of the genogram on their medical care.

SELF-ADMINISTERED GENOGRAM RESULTS

Twenty-two patients participated in the study (8 males and 14 females) with ages ranging from 20 to 66 years. The skeleton and blank recording pages were both rated somewhat difficult to complete with 1 patient unable to complete the blank genogram and 2 patients unable to complete the skeleton genogram. Nineteen of the 22 patients completed their genograms; 17 patients were finished before the patient was seen by the physician, and the other 2 patients reported that they were nearly finished by that time. It took the subjects a median of 20 minutes (range of 5 to 30 minutes) to complete their genograms.

Fifteen of the 22 subjects stated that remembering dates and other information about distant relatives (i.e. grandparents, aunts, uncles, and in-laws) caused the greatest difficulty. In fact, every completed form contained at least one omission of information about these distant relatives, and at least one distant family member had been omitted in 11 of the 19 completed

forms. In addition, 9 of the 19 forms did not include the family interaction information which was requested. These omissions easily were corrected, however, during the brief followup interview with the investigator.

Thirteen of the 19 patients completing their genograms felt that it would have a positive impact on their medical care. Among the reasons given were that the physician would have important family information available, that the genogram showed how the individual functioned within the family, and that the convenience of having the whole family's record on a single page would be useful. A few patients even reported that by completing the genogram they had learned something about their own family. It should be noted that these impressions were reported after the completion of the genogram and not after the patients had an opportunity to observe exactly how the information was used in their care. Their opinions may be different after that experience.

SELF-ADMINISTERED GENOGRAM DISCUSSION

Despite its potential as a tool for gathering and organizing family information, the genogram probably is underutilized in day-to-day clinical care primarily due to physician time constraints. This modest pilot study indicates, however, that many patients may be able to complete self-administered genograms in the waiting room before seeing the physician, thereby overcoming the time problem. Because of its limited size, this study does not elucidate what factors are related to successful completion of self-administered genograms such as education or age of patient or family composition.

The use of self-administered genograms may reduce but does not eliminate the need for physician time to be spent on taking a family history. Minor errors and omissions are relatively frequent but can be corrected easily when the genogram is reviewed by the physician. In addition, family medical and psychosocial problems are not included on the self-administered form and would need to be explored by the physician. The presence of the basic genogram probably facilitates this additional history taking, but further work may demonstrate that patients can provide this additional information in a self-administered format as well.

Patient acceptance must be considered when evaluating the potential role of self-administered genograms in clinical care. Although somewhat anecdotal, the patients' responses indicate that they appreciate the relevance of the task to their medical care, and that they take the exercise seriously without much resistance. These findings are only tentative, however, and must be corroborated in future work.

The results of this pilot study have guided the revision of the self-administered genogram protocol. The current edition includes a cover letter describing the genogram and its intended use by the physician, step-by-step instructions for completing the genogram, a three-generation skeleton, and two sample genograms, one of which illustrates how to record a second mar-

riage. Studies are now underway to determine the reliability and validity of this revised packet and to determine the impact of the self-administered family genogram on clinical care.

SUMMARY

A survey of family physicians in New Jersey indicates that while most of the physicians obtain family histories from new patients and, on average, devote approximately six minutes to this activity, the physicians rarely use family genograms. Most of the surveyed physicians did, however, have a favorable attitude toward genograms for reviewing or retrieving family information. A pilot study of self-administered genograms suggests that many patients could complete their own genograms before seeing the physician, and that patients consider the genogram relevant to their care. Together, these two studies suggest that self-administered genograms may be acceptable to both physicians and patients, and that self-administered genograms may be able to overcome one of the barriers to the use of genograms by practicing physicians—time. Further development and testing of a self-administered genogram protocol appear to be warranted.

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Medical Education Morristown

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(Established by Governor—March 1980)

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(Liaison requested by AMA—October 7, 1951)

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Finance and Budget, Consultant Audubon
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Blindness—New Jersey, National Society To Prevent

(Requested by the National Society To Prevent Blindness—
New Jersey—March 19, 1978)

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Conservation of Vision North Plainfield

Blood Bank Association, New Jersey

(Liaison requested by New Jersey Blood Bank Association—April 25, 1969)

Frank Campo, M.D. Trenton

Blood Banking Task Force for New Jersey

(University of Medicine and Dentistry of New Jersey—
October 1981)

Frank Campo, M.D. Trenton

Commissioner's Physician Advisory Committee

(Representation requested by State Commissioner of Health
to assist in the Diagnosis Related Group (DRG) concept—
June 1977)

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*Douglas M. Costabile, M.D., Murray Hill, designated as Presi-
dent's Representative for 1985-1986.

Commissioner's Special Committee on Health Issues

(Representation requested by Commissioner of Health—July
1983)

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Dental Health, State Task Force for Better

(Representation requested by Department of Health—
January 30, 1985)

Glenn P. Lambert, M.D. Flemington

Diabetes Coordinating Council

(Representation requested by Department of Health—
November 10, 1980)

Arthur Krosnick, M.D. Trenton

Drug and Alcohol Problems, Statewide Committee To Assist Local School Districts with

(Representation requested by Department of Education, Re-
gional Curriculum Services Unit—South—June 5, 1984)

Ed Reading, M.Div. Lawrenceville

Drug Utilization Review Council, New Jersey

(Representation requested by Department of Health—
December 19, 1984)

Harry M. Woske, M.D. Flemington

Education, State Department of

(Liaison requested by the Assistant Commissioner of Educa-
tion—September 21, 1958)

Glenn P. Lambert, M.D., Chairman, Special
Committee on Child Health Flemington

Emergency Medical Personnel and Hospitals, Division on Women Training Program for

(Representation requested by Department of Community Af-
fairs, Division on Women—August 2, 1984)

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(Recommended to Executive Director, Statewide Health Coor-
dinating Council, Department of Health—1974)

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Health Professions Education Advisory Council

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tion—1976)

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Highway Safety Policy Advisory Council, New Jersey

(Nomination for appointment by Governor requested by Director, Department of Law and Public Safety, Division of Motor Vehicles—March 19, 1984)

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JEMPAC, Conference Committee with

(Established at request of JEMPAC—June 25, 1967)

Irving P. Ratner, M.D., Chairman, Council on
Legislation Willingboro
Joseph W. Fleisher, M.D., Chairman, Council on
Medical Services Bayonne
Palma E. Formica, M.D., Second
Vice-President Old Bridge

Legislation

(1) Federal Keymen (Mechanism established by MSNJ—April 4, 1954, to serve as official intermediaries between MSNJ and the Federal Legislators): 14 Congressional District Keymen and 2 Senatorial Keymen.

(2) State Keymen (Mechanism established by MSNJ—July 13, 1952): Keymen in 40 Legislative Districts/21 Component Societies.

Medical Assistance Advisory Council

(At the request of the New Jersey Department of Human Services—1980)

Thomas S. Bellavia, M.D.* Hasbrouck Heights
*Appointment pending

Medical Assistants, State of New Jersey, Inc., American Association of

(Liaison requested by Association—September 15, 1963)

Giovanni Lima, M.D. Kearny

Medical Liaison Committees

(High-level conference groups for discussion and consideration of items of mutual interest)

Ralph J. Fioretti, M.D., President Rochelle Park
Edward A. Schauer, M.D., President-Elect Farmingdale
Harry M. Carnes, M.D., First Vice-President Audubon
Palma E. Formica, M.D., Second
Vice-President Old Bridge
Frank Y. Watson, M.D., Immediate

Past-President Glen Ridge
Arthur Bernstein, M.D., Secretary South Orange
Paul J. Hirsch, M.D., Treasurer Bridgewater
Vincent A. Maressa, Executive Director Lawrenceville

(1) Medical-Dental

(Liaison requested by the Dental Society—June 10, 1951)

(2) Medical-Hospital

(Liaison established by MSNJ—October 25, 1953)

(3) Medical-Legal

(Liaison established by MSNJ—October 25, 1953)

(4) Medical-Nursing

(Liaison established by MSNJ—April 4, 1954)

(5) Medical-Osteopathic

(Liaison requested by Osteopathic Association—September 17, 1961)

(6) Medical-Pharmaceutical

(Liaison established by MSNJ—July 26, 1953)

Mental Retardation, Governor's Council on the Prevention of

(Appointed by the Governor—June 22, 1984)

Stanley S. Bergen, Jr., M.D. Newark

Pharmaceutical Assistance to the Aged and Disabled Advisory Council

(Appointed by Commissioner of the Department of Human Services—physician representation requested by Division of Medical Assistance and Health Services—December 19, 1980)

Frank J. Malta, M.D. Toms River

Pharmacopeial Convention, the United States

(MSNJ invited to appoint a delegate to serve—August 1980)

Frank J. Malta, M.D. Toms River

Physician Jury Service, Ad Hoc Committee on

(Appointed by President, pursuant to resolution adopted by 1983 House of Delegates)

L. Arne Skilbred, M.D., Chairman Glen Ridge
John J. Crosby, Jr., M.D. Jersey City
Howard H. Lehr, M.D. Fanwood
Irving P. Ratner, M.D. Willingboro
Bernard A. Rineberg, M.D. New Brunswick

Poison Information and Education System, Advisory Board to New Jersey

(Representation requested by Department of Health—January 21, 1983)

Rudolf E. Schwaeble, M.D. Mendham

Prescription Abuse Avoidance Committee

(Representation requested by State Board of Medical Examiners—April 4, 1983)

David I. Canavan, M.D. Lawrenceville
Daniel P. Greenfield, M.D. Short Hills

Public Health Council, New Jersey

(Nomination for appointment by Governor to serve a seven-year term requested by Department of Health—June 1, 1984)

Henry A. Katz, M.D.* Parsippany
*Appointment pending

Radiation Protection, Advisory Committee on Nuclear Medicine to New Jersey Commission on

(Consultants in nuclear medicine appointed by Commission—November 20, 1966)

Henry J. Powsner, M.D. Princeton

Radiation Protection, Consultant Serving New Jersey Commission on

(Nomination for appointment to Commission requested March 17, 1963)

Frank Gingerelli, M.D. Hackensack

Radiologic Technology Board of Examiners

(Agency of the Commission on Radiation Protection, Department of Environmental Protection—appointed by Governor 1983)

Armando F. Goracci, M.D. Woodbury

Resolutions, Committee on Annual Meeting

(Established by Board of Trustees—July 18, 1971, to review all resolutions in advance of the Annual Meeting)

Howard D. Slobodien, M.D., Chairman Metuchen
Alexander D. Kovacs, M.D. Sun City, AZ
Frank Y. Watson, M.D., Immediate

Past-President Glen Ridge
Armando F. Goracci, M.D., Alternate Woodbury

Safety Council, New Jersey State

(Provided in Council Bylaws—1962)

Ralph J. Fioretti, M.D., President Rochelle Park

George P. Bisgeier, M.D., President's Representative—Chairman, Special Committee on Occupational Health, Worker's Compensation and Rehabilitation Newark

State Board of Medical Examiners

(Trustees designated to attend monthly meetings on a rotating basis—per Board of Trustees December 15, 1974, and per Board of Trustees—August 8, 1979)

Edward A. Schauer, M.D., President-Elect Farmingdale
Martin E. Johnson, MSNJ Staff Member Lawrenceville

Statewide Health Coordinating Council (SHCC) and/or its Review Committee

(Liaison established January 15, 1978—appointed by President of MSNJ)

Palma E. Formica, M.D., Second Vice-President* Old Bridge
A. Ronald Rouse, MSNJ Staff Member Lawrenceville
*Appointed 1985. Doctor Formica will serve in this capacity until she becomes President, at which time the new Second Vice-President will serve as her replacement.

Student Association, Medical Society of New Jersey

(Formed July 17, 1977)

Palma E. Formica, M.D., Member of Board of Trustees—per Board, October 21, 1979 Old Bridge
Kevin Kerlin, Student, New Jersey Medical School Newark
Euton M. Laing, Student, Rutgers Medical School Piscataway
Susan E. Kirk, Student, Rutgers Medical School Camden

UMDNJ, Foundation of the

(MSNJ representative appointed yearly by the Board of Trustees to serve as a trustee, pursuant to the Bylaws of the Foundation—1979)

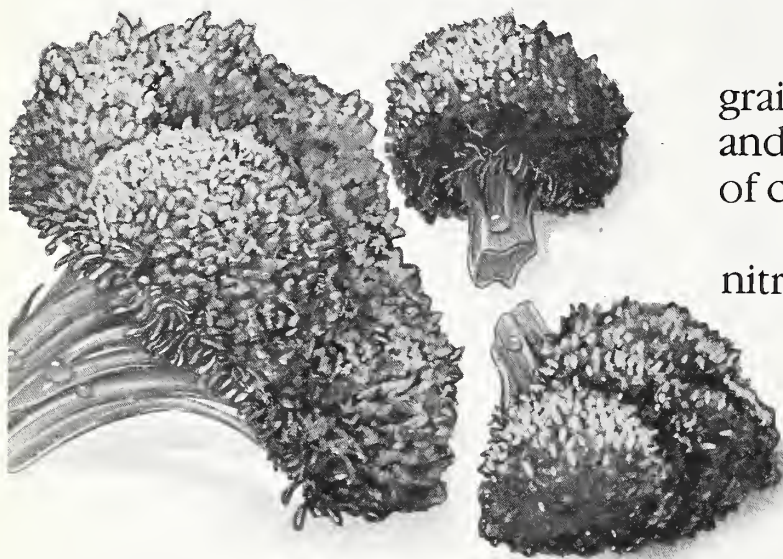
Arthur Bernstein, M.D. South Orange

Widows and Orphans of Medical Men of New Jersey, the Society for the Relief of

(Liaison requested by Society—May 17, 1959)

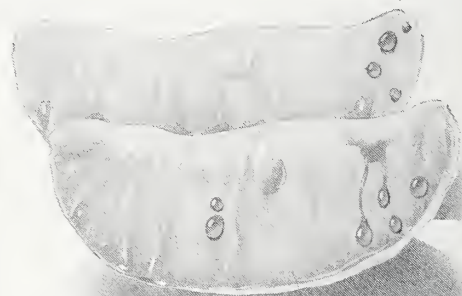
Joseph R. Jehl, M.D. Clifton

A defense against cancer can be cooked up in your kitchen.



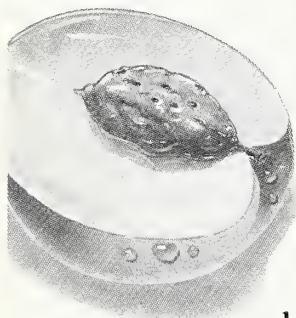
Fruits, vegetables, and whole-grain cereals such as oatmeal, bran and wheat may help lower the risk of colorectal cancer.

Foods high in fats, salt- or nitrite-cured foods like ham, and



There is evidence that diet and cancer are related. Some foods may promote cancer, while others may protect you from it.

Foods related to lowering the risk of cancer of the larynx and esophagus all have high amounts of carotene, a form of Vitamin A which is in cantaloupes, peaches, broccoli, spinach, all dark green leafy vegetables, sweet potatoes, carrots, pumpkin, winter squash and tomatoes, citrus fruits and brussels sprouts.



Foods that may help reduce the risk of gastrointestinal and respiratory tract cancer are cabbage, broccoli, brussels sprouts, kohlrabi, cauliflower.

fish and

types of sausages smoked by traditional methods should be eaten in moderation.

Be moderate in consumption of alcohol also.

A good rule of thumb is cut down on fat and don't be fat.

Weight reduction may lower cancer risk. Our 12-year study of nearly a million Americans uncovered high cancer risks particularly among people 40% or more overweight.

Now, more than ever, we know you can cook up your own defense against cancer. So eat healthy and be healthy.

No one faces cancer alone.



STATEMENT OF OWNERSHIP, MANAGEMENT, AND CIRCULATION

(Required by 39 U.S.C. 3685)

1. Title of Publication: THE JOURNAL of the Medical Society of New Jersey.
1A. Publication No.: 0025-7524.
2. Date of Filing: September 17, 1985.
3. Frequency of Issue: Monthly.
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5. Location of the Headquarters or General Business Office of the Publisher: 2 Princess Road, Lawrenceville, Mercer County, NJ 08648.
6. Names and addresses of publisher, editor, and managing editor: Publisher, Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648. Editor, Arthur Krosnick, M.D., 2 Princess Road, Lawrenceville, NJ 08648. Managing Editor, Geraldine R. Hutner, 2 Princess Road, Lawrenceville, NJ 08648.
7. Owner (if owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.): Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648 (a nonprofit corporation of New Jersey).
8. Known bondholders, mortgages, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities: none (a nonprofit corporation of New Jersey).
9. For completion by nonprofit organization authorized to mail at special rates (Section 411.3, DMM only). The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes have not changed during preceding 12 months.
10. Extent and nature of circulation:

Extent and nature of circulation	Actual no. of copies of	
	Average no. copies each issue during preceding 12 months	single issue published nearest to filing date
A. Total no. copies printed (net press run)	10,850	10,825
B. Paid circulation		
1. Sales through dealers and carriers, street vendors, and counter sales	—	—
2. Mail subscriptions	10,026	10,005
C. Total paid circulation (sum of B1 and B2)	10,026	10,005
D. Free distribution by mail carrier or other means— samples, complimentary, and other free copies	589	589
E. Total distribution (sum of C and D)	10,615	10,594
F. Copies not distributed		
1. Office use, left-over, unaccounted, spoiled after printing	235	231
2. Return from new agents	—	—
G. Total (sum of E, F1, and 2—should equal net press run shown in A)	10,850	10,825

11. I certify that the statements made by me above are correct and complete.
(signed) Arthur White

Director of Finance and Administrative Services

12. For completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual). 39 U.S.C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matters at such rates." In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the phased postage rate presently authorized by 39 U.S.C. 3626 (signed).

DOCTORS' NOTEBOOK

*Trustees' Minutes; UMDNJ
Notes; Physicians Seeking
Location in New Jersey*

Trustees' Minutes September 15, 1985

A regular meeting of the Board of Trustees was held on Sunday, September 15, 1985, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . .

(1) **Certificate of Need for Physicians, S-2869** . . . Noted that MSNJ maintains its opposition to certificate of need for physicians and that the Hospital Association does not have a universally accepted position on the issue.

(2) **Meeting of Executive Committees of MSNJ and PRO of New Jersey, Inc.** . . .

(a) **Prior Approval for Admission and/or Procedures for Patients—Resolution #30E (1985)** . . . Noted that a complaint was filed with the Department of Insurance requesting that carriers using preadmission certification programs be required to explain fully all coverage limitations to their insureds.

(b) **Scheduling of PRO Appeals—Resolution #29E (1985)** . . . Noted that the review cycle will be extended to grant physicians more time to schedule appearances.

(c) **NJ PRO Criteria—Resolution #26 (1985)** . . . Noted that the criteria have been revised and are labeled as a screening protocol for nurses and disavowed as a standard practice.

(d) **Representation of MSNJ on PRO Board** . . . Voted to request that MSNJ be given the opportunity to have an observer present at PRO Board meetings, and in that event a representative of MSNJ would be designated to serve on the PRO liaison committee.

(3) **PRO Memorandum to Chiefs of Medical Staffs** . . . Noted that copies of a PRO memorandum concerning the possibility of premature discharges of Medicare patients will be sent to members of the Board.

Report of Executive Director . . .

(1) **MSNJ 1985 Membership** . . . Noted that paid membership as of August 1985 totaled 7,424.

(2) **MSNJ Financial Statements** . . . Reviewed and approved MSNJ's financial statements for the periods ending June 30, July 31, and August 31, 1985.

(3) **Litigation** . . .

(a) **Alfone v Area VII PRO, New Jersey Blue Cross, Monmouth Medical Center, MSNJ, et al.** . . . Noted that MSNJ is included in a lawsuit involving a case of denial of benefits for lack of medical necessity; a favorable outcome is anticipated.

(b) **Subordinated Loan Certificates—IRS** . . . Noted that a summary of the determination on the subordinated loan case will be in the newsletter and in a direct mailing.

(4) **SBME—Proposed Regulations** . . .

(a) **Disposal of Fetal Tissue** . . . Noted that this amendment would require physicians performing abortions in clinics to make suitable arrangements to dispose of fetal tissue.

(b) **Labeling of Expiration Date on Dispensed Medications** . . . Noted that this amendment would require physicians dispensing medication to include the expiration date of the medication on the container label.

(c) **Educational Requirements for Clinical Clerkships** . . . Noted that this amendment would replace the

Medical Science Knowledge Profile with a new Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS).

(5) **Contracting Checklist** . . . Were informed that a checklist to assist physicians in evaluation of medical service contracts is being prepared for distribution to the membership.

(6) **Insurance Department Task Force on Professional Liability** . . . Noted that a report of the Task Force on Medical Malpractice was released; Peter Sweetland, President of MIENJ, a member of the Task Force, presented recommendations (see page 865).

UMDNJ . . . Noted that Dr. David Goldenberger, UMDNJ-Newark, was the recipient of an Outstanding Investigator Award from the National Cancer Institute.

Council on Legislation . . . Noted that the Board of Trustees approved all the positions recommended by the Council on Legislation with the exception of A-3273 where the action was changed to disapproved. **Note:** A-3273 provides for the licensing of nutritionists and the regulation of their practice.

Council on Public Relations . . . Approved the individual projects that have been carried out on a continuous basis each year by the Council.

Standing Committee on Annual Meeting . . . Approved the proposed daily schedule for the 1986 Annual Meeting to be held at the Westin Bellevue Stratford in Philadelphia from May 14, 1986, to May 18, 1986.

Standing Committee on Medical Education . . . Approved the following recommendation:

That MSNJ cosponsor the Workshop for Medical Educators to be held on Wednesday, December 4, 1985, at the Executive Offices of MSNJ. (Cosponsorship will not involve expenditure of MSNJ funds.)

Special Committee on Impaired Physicians . . . Approved the following three recommendations: That a Medical Student Assistant Program under the jurisdiction of the Impaired Physicians Program be established.

That the staff of the Impaired Physician Program be authorized to investigate with other state medical societies, the AMA, AOA, and the

auxiliaries of these organizations, the possibility of joint sponsorship of a Regional Meeting of the Medical Family to be held in 1987.

That the Policy for Services To Be Provided to Family Members by the Impaired Physicians Program be approved as program protocol.

JEMPAC . . . Approved the following recommendation:

That William Allgair, M.D., of Middlesex County, be appointed to the JEMPAC Board of Directors, to fill the unexpired term of Norval Kemp, M.D.

Old Business . . .

(1) Proposed Same-Day Surgery Regulations . . . Noted that the Department of Health will form an expanded Commissioner's Physician Advisory Committee and interested parties will be asked to be a part of this Committee.

(2) State Board of Medical Examiners' Newsletter . . . Denied a request by the Union County Medical Society that a letter of protest be sent to the SBME for circulating a list of physicians who have been disciplined by the Board.

(3) Medicare "Participating Physician" Program . . . Noted that the AMA sent a communication describing the provisions of the current law concerning the participating physicians program to members who are in full-time office or hospital-based practice.

New Business . . .

Conflicts of Interest Disclosure . . . Requested that a revised version of the conflicts of interest form be prepared and submitted for consideration at the next Board meeting.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

In New Jersey, an estimated 200,000 people are afflicted with Alzheimer's disease, the nation's fourth leading cause of death. The impact of this degenerative and terminal disease is devastating to victims and their families. For several years now, the Community Mental Health Center of the UMDNJ-Rutgers Medical School in Piscataway has operated a day program for victims of Alzheimer's and other dementing illnesses through a

special unit called Community Outreach Program for Senior Adults (COPSA).

I am very happy to report that this effort to combat Alzheimer's disease took a major step forward a few weeks ago with the announcement that UMDNJ's Piscataway campus will be home to a major multi-disciplinary Institute to care for victims of the disease and to assist their families. The Institute for Alzheimer's Disease and Related Disorders will be the first of its kind in New Jersey, bringing together initiatives in research, professional education, and patient services to advance our understanding and knowledge of Alzheimer's, provide more comprehensive diagnosis and treatment, and better equip the families of victims to provide care and to cope.

The Institute will serve as a resource center, diagnostic clinic, and day program. The resource center will provide counseling, information, and case management to families of Alzheimer's victims; assist community agencies working with those victims; and help support and expand services. The Institute will process calls with the aid of an 800 telephone number. As many as 500 referrals per year would be made from the resource center to the diagnostic clinic.

The clinic will work with the UMDNJ-Rutgers Medical School departments of family medicine, neurology, and psychiatry to offer comprehensive diagnoses of Alzheimer's, making distinctions between reversible and irreversible dementias

and recommending appropriate treatment. Inpatient diagnosis and treatment also would be arranged when possible. And the clinic would serve as a training site for medical students, interns, and residents.

The day program would provide complete day treatment to adults diagnosed with Alzheimer's and other dementing illnesses, plus case management services to clients and families.

The Institute, a single-story, 10,000-square-foot facility costing an estimated \$800,000, will be built adjacent to the Community Mental Health Center off Hoes Lane in Piscataway. Although the details for financing the Institute's construction remain to be worked out, the new building is expected to be completed by November 1986.

A \$500,000 special state appropriation has been earmarked for operating the Institute and its programs. The appropriation was provided through a resolution sponsored earlier this year by Assemblyman Joseph Chinnici (R-Cumberland). The Assemblyman's efforts in this area came in response to the findings of an Alzheimer's Disease Study Commission that concluded New Jersey needed to take a comprehensive approach to combating Alzheimer's.

The commission's formation was spurred by the Alzheimer's Disease Support Network, a statewide organization of more than 700 Alzheimer's families and professionals who were brought together through the efforts of the COPSA program at our Community Mental Health

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Name _____

Address _____

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Center. This network played a major role in drawing attention to the Alzheimer's problem in New Jersey and was instrumental in securing legislation, back in the fall of 1983, that established the study commission. The legislation was sponsored by Assemblyman David Schwartz (D-Middlesex) and signed by Governor Kean.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—David J. Valacer, M.D., 42 Wachusett Ave., Shrewsbury, MA 01545. University of Vermont 1975. Also, immunology. Board eligible.

Board certified (PED). Group, partnership, solo. Available.

CARDIOLOGY—David A. Gehring, M.D., P.O. Box 5610, Hobbs, NM 88241. University of Pittsburgh 1956. Also, internal medicine. Board eligible. Board certified (IM). Group or partnership. Available.

DERMATOLOGY—Steven Fenichel, M.D., 337 S. Harvey, Oak Park, IL 60302. Royal College of Surgeons (Ireland) 1976. Board certified. Solo, partnership, group. Available.

GENERAL PRACTICE—Susan F. Stickels, M.D., 1913 E. Kenmore Pl., Shorewood, WI 53211. Board certified. Group or HMO. Available.

IMMUNOLOGY—David J. Valacer, M.D., 42 Wachusett Ave., Shrewsbury, MA 01545. University of Vermont 1975. Also, allergy. Board eligible. Board certified (PED). Group, partnership, solo. Available.

INTERNAL MEDICINE—Tsodil Aronin, M.D., 1945 Ocean Ave., Apt. 6, Brooklyn, NY 11230. Vitebsk Medical Institute (USSR) 1954. General practice, group, clinic, hospital. Available.

Neil H. Caplan, M.D., 27 W. Penn St., Long Beach, NY 11561. Bowman Gray. Board eligible. Outpatient or clinic setting. Available.

C.C. Enu, M.D., c/o Dr. Foins, 291 Decatur St., Brooklyn, NY 11233. Albany Medical 1969. Board certified. Group, hospital, partnership, HMO. Available.

David A. Gehring, M.D., P.O. Box 5610, Hobbs, NM 88241. University of Pittsburgh 1956. Also, cardiology. Board certified. Board eligible (CARD). Group or partnership. Available.

Eli R. Goldner, M.D., 2841 W. Rosemont, Chicago, IL 60659. University of Rome (Italy) 1980. Board eligible. Partnership or group. Available February 1986.

Nancy Hoffman-Wadhwa, M.D., One Maidstone Ct., Apt. M, Baltimore, MD 21237. St. George University (Grenada) 1982. Board eligible. Available.

Cruz-Elena Sundquist, M.D., 37 1st St., Keyport, NJ 07735. Harvard 1984. Hospital based or clinic. Available.

Viswanath P. Vasudevan, M.D., 102-12 65th Ave., Apt. D-64, Forest Hills, NY 11375. University of Bombay 1976. Also, pulmonary. Board certified. Also, board certified (PUL). Solo or group. Available.

THE MEDICAL SOCIETY OF NEW JERSEY

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PRESIDENT'S FORUM

Hosted by Ralph J. Fioretti, M.D.
President, MSNJ

STATE OF THE ART

Hosted by Frank Y. Watson, M.D.
Past-President, MSNJ

on the second and fourth Thursdays of each month at 1:00 p.m.

Topics will include:

"American Association of Retired Persons; An Impact on Medicine"; "The Society's Stand on Proposed Legislation"; "The PROs"; "Malpractice Tort Reform"; "Hospital Staff and Future of Medicine"; "Is There a Need for CNs?"

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Programs may be taped for alternate viewing times.

Dom Wadhwa, M.D., One Maidstone Ct., Apt. M, Baltimore, MD 21237. St. George University (Grenada) 1982. Board eligible. Available.

NEUROLOGY—Kala L. Paul, M.D., 921 Marine Dr., #113, Galveston, TX 77550. University of Texas 1981. Board eligible. Group. Available February 1986.

OBSTETRICS/GYNECOLOGY—William King, M.D., 9112 Abigail Dr., #1-C, Baltimore, MD 21237. Wayne State 1975. Board eligible. Group, partnership. HMO, hospital based. Available.

James E. Veintimilla, M.D., 9 Wolfpack Ct., Trenton, NJ 08619. Ecuador 1957. Board eligible. Small-town practice. Available.

OCCUPATIONAL MEDICINE—Alexander A. Boytar, M.D., 493 Creek Rd. Ext., Lewiston, NY 14092. Budapest 1948. Group, salaried, industrial. Available.

PEDIATRICS—Archana Jain, M.D., 44 Spring House Ct., Wilmington, DE 19810. S.N. Medical (India) 1981. Board eligible. Partnership. HMO, clinic. Available July 1986.

PULMONARY—Thomandram S. Sekar, M.D., 1420 Deerbrook Ct., Bluffton, IN 46714. Stanley Medical College 1970. Board certified. Group, partnership, solo, hospital. Available.

Viswanath P. Vasudevan, M.D., 102-12 65th Ave., Apt. D-64, Forest Hills, NY 11375. University of Bombay 1976. Also, internal medicine. Board certified. Also, board certified (IM). Solo or group. Available.

Harlan R. Weinberg, M.D., 337 N. Palm Dr., Apt. 8, Beverly Hills, CA 90210. University of Connecticut 1981. Board certified. Also, board certified (IM). Hospital. Available July 1986.

SURGERY—Eduardo Harley, M.D., 177 Lincoln Blvd., Kenmore, NY 14217. Cayetano Heredia (Peru) 1975. Board certified. Also, oncology surgery. Group, partnership, solo. Available.

M. Farrukh Ali Khan, M.D., 785 Oak Ridge Dr., P.O. Box AF, Lisbon, ND 58054. B.S. King Edward Medical College (Pakistan) 1975. Available.

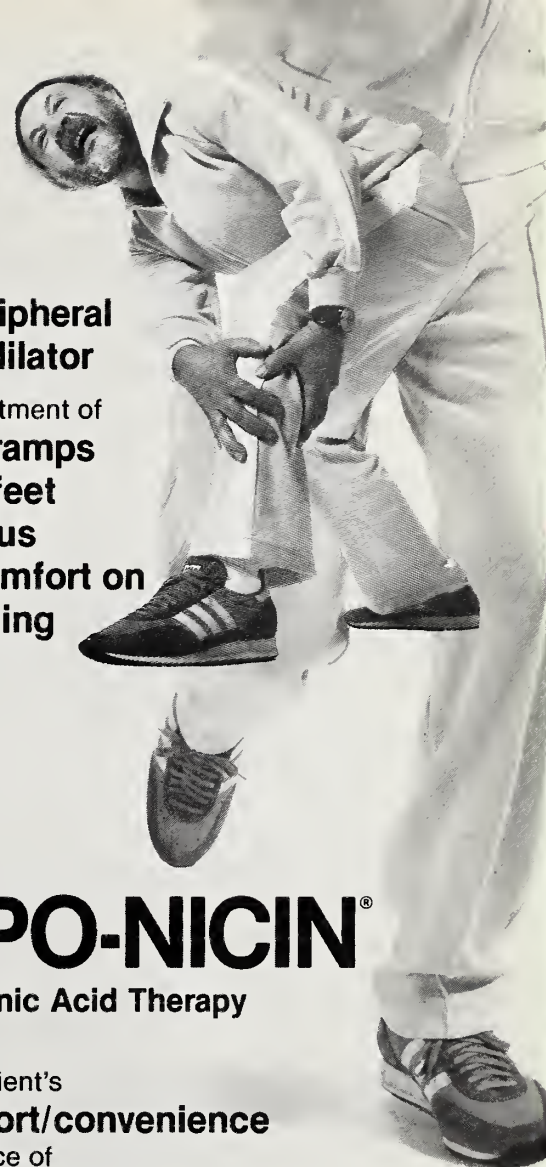
Lance A. Lieberman, M.D., 2046 76 St., Brooklyn, NY 11214. Rutgers 1980. Board eligible. Also, vascular surgery. Solo, group, partnership. Available July 1986.

Anthony J. Menichino, M.D., 82 Niagara Falls Blvd., Buffalo, NY 14214. Guadalajara (Mexico) 1973. Board eligible. Group, partnership, solo. Available.

Steven H. Untracht, M.D., 224 Kennedy Dr., #310, Malden, MA 02148. Chicago 1981. Board eligible. Small group or partnership. Available July 1986.

UROLOGY—Barry R. Shepard, M.D., 30 So. Central Ave., Valley Stream, NY 11580. SUNY 1979. Board eligible. Available.

A peripheral vasodilator
for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing



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in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

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Riboflavin (B-2) 2 mg.
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DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

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Thiamine HCL (B-1) 25 mg.
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Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

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1986 MEETING ANNOUNCEMENT —WEEKEND IN NEW YORK

INFECTION/IMMUNOLOGY in Obstetrics and Gynecology

- Friday and Saturday, January 3-4, 1986
- New York, N.Y.
- AMA and ACOG Accreditation—Tuition includes: luncheons, refreshments, and syllabus
- Program Chairman, William J. Ledger, M.D., New York Hospital/Cornell University College of Medicine

Topics include: sexually transmitted diseases ... genital herpes ... acquired immune deficiency syndrome (AIDS) in women and infants.

CONTACT: Program Coordinator, c/o

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CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE
CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

WEDNESDAY, DECEMBER 4, 1985

ELECTROPHYSIOLOGIC TESTING

MODERATOR: SCOTT R. SPIELMAN, M.D.

- | | | |
|------|---|----------------------------------|
| 3:00 | CASE PRESENTATION: SYNCOPE | <i>Stuart Snyder, M.D.</i> |
| 3:30 | DISCUSSION, INCLUDING RESULTS OF EP TESTING
AND CONTROL OF VENTRICULAR TACHYCARDIA | <i>Scott R. Spielman, M.D.</i> |
| 4:00 | CASE PRESENTATION: SUPRAVENTRICULAR
TACHYCARDIA | <i>Pasquale F. Nestico, M.D.</i> |
| 4:30 | DISCUSSION, INCLUDING RESULTS OF EP
TESTING FOR BYPASS TRACTS | <i>Steven P. Kutalek, M.D.</i> |
| 5:00 | QUESTIONS AND ANSWERS: THE AUDIENCE | |

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****WINE & CHEESE SERVED FOLLOWING CONFERENCE****

- 23 Visiting Professorship Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center and AMNJ*)
- 29 Fluid and Electrolyte Imbalance**
10:30 A.M.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)

NEUROLOGY/PSYCHIATRY

December

- 2 Effects of Masochism on a Young Girl's Life Goals**
8:15-10:15 P.M.—111 Ridgewood Ave., Glen Ridge
(*Essex Psychiatric Seminar and AMNJ*)
- 5 Case Seminars**
- 19** 8-10 P.M.—312 Harding Dr., South Orange
(*Advanced Psychiatric Study Group and AMNJ*)
- 5 Cocaine Abuse—Current and Innovative Treatment Approaches**
- 12 Relevant Forensic Issues: Whose Fault Is It?**
- 19 Madness and Nuclear Threats**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 6 Principles and Technique of Individual Psychotherapy**
1:30-5 P.M.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital, Div. of Mental Health, and AMNJ*)

January

- 2 Case Seminars**
- 16** 8-10 P.M.—312 Harding Dr., South Orange
(*Advanced Psychiatric Study Group and AMNJ*)
- 6 Depression and Burn-Out in an Intensive Care Nurse**
8:15-10:15 P.M.—4 Garden Place, Nutley
(*Essex Psychiatric Seminar and AMNJ*)

- 9 A Night at the Movies: "A Private Life"**
8 P.M.—Hackensack Medical Center
(*NJ Psychoanalytic Society and AMNJ*)

PEDIATRICS

January

- 14 Pediatric Grand Rounds**
9:30 A.M.—Elizabeth General Medical Center
(*Newark Beth Israel Medical Center and AMNJ*)
- 18 Child Sexual Abuse**
8 A.M.—Newcomb Hospital, Vineland
(*Newcomb Hospital*)

RADIOLOGY

December

- 12 Peripheral Vascular Disease Evaluation with Ultrasound**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(*NJ Institute of Ultrasound in Medicine and AMNJ*)
- 19 Radiology Meeting**
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(*Radiological Society of NJ and AMNJ*)

January

- 9 Neonatal Neurosonography**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(*NJ Institute of Ultrasound in Medicine and AMNJ*)
- 15 Dinner Meeting**
6:30-9:30 P.M.—The Manor, West Orange
(*Radiotherapy Section—AMNJ*)
- 16 Radiology Meeting**
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(*Radiological Society of NJ and AMNJ*)

SURGERY

December

- 3 Surgical Grand Rounds**
- 10** 7-9 A.M.—New Conference Center, Hackensack
(*Hackensack Medical Center and AMNJ*)
- 7 Annual Clinical Meeting**
8 A.M.-5 P.M.—Berkeley Carteret Hotel, Asbury Park
(*NJ Chapter, American College of Surgeons and AMNJ*)
- 7 Vascular Surgery: A Personal Historic Review (Michael E. DeBakey, M.D.)**
9-10:30 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(*St. Joseph's Hospital and Medical Center*)
- 19 Surgical Procedures for Chronic Pancreatitis**
12 noon-1 P.M.—St. Mary's Hospital, Orange
(*St. Mary's Hospital and AMNJ*)

January

- 7 Surgical Grand Rounds**
- 21** 7-9 A.M.—New Conference Center, Hackensack
(*Hackensack Medical Center and AMNJ*)
- 28 Loss, Grief, and the Surgeon**
8-10 P.M.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)

MISCELLANEOUS

December

- 4 Annual Meeting**
8 A.M.-3 P.M.—Medical Society of NJ, Lawrenceville
(*Association for Hospital Medical Education of NJ and AMNJ*)
- 4 DRG/Cost Containment**
10:30 A.M.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)

LETTERS TO THE EDITOR

Funk; One-Day Plastic Surgery

Funk

August 12, 1985

Dear Doctor Krosnick:

Funk is a new word yet to find its way into the new American and English dictionary. This word describes college students who are in a temporary period of nonproductivity, with a sense of not cerebrating properly. The cause is unknown although mononucleosis, poor dietary habits, partying, lack of sleep, and under-exercising are thought to play a role. "Funk" per-

sists for weeks and, hence, exam performance is of poorer quality than normal. Even the sexual appetite decreases. Social and political judgment is cloudy. It is like having "a veil over your brain." The recurrence rate of funk is high. It has not been reported in blue collar workers or ghetto dwellers as compared to college students.

This is a period where words beginning with "f" predominate all lay magazines, yet nothing is said of the most important of these—namely "funking." It is time that this bizzare state of mind is truly recognized and at least placed in our medical parlance and dictionary so that we can begin to research its cause.

(signed) Leon G. Smith, M.D.

August 20, 1985

Dear Doctor Krosnick:

Dr. Smith is mistaken in saying that "funk" does not appear in English or American dictionaries. It appears in Webster's *Twentieth Century*, Webster's *New Collegiate*, and Webster's *New World*, which are the only English dictionaries I have at hand, and is not even described as colloquial. It also is mentioned several times in Roget's *Thesaurus* in the same senses. The commonest meaning is fear, as noun or verb, and a derived meaning is to avoid because of fear or to shirk. I believe that its relative lack of use outside the college population is because other terms are used for the same behavior, such as malingering in the military and perhaps goofing-off.

It does not appear to be related to the jazz use of funky, "having an earthy quality or style derived from early blues."

It may well have all the causes mentioned by Dr. Smith, but I really doubt that placing the word in medical dictionaries is likely to encourage research or research support. "Malingering" has been in the medical books for many years without attracting much interest. Perhaps the time is not yet ripe to find funds to study yet another "f." Indeed, this subject might be thought faddish or facetious by the finicky or fastidious. Perhaps it is too fuzzy to be a fertile area of research.

(signed) A. Arthur Sugerman, M.D.

One-Day Plastic Surgery

August 14, 1985

Dear Doctor Krosnick:

I enjoyed the review of *One Day Plastic Surgery, A Consumers' Guide to Savings and Safety* by Richard Bloomenstein, M.D., and Arne Finger in the August issue of *The Journal*. Your reviewer obviously appreciated most of the qualities of this fine patient information book on office surgery. However, he overlooked the important discussion concerning anesthesia.

As I stated in the foreword to the book, I have taught and practiced anesthesiology for many years in the hospital and outpatient settings. I thoroughly endorse Dr. Bloomenstein's feelings concerning use of local anesthesia combined with intravenous sedation monitored by a physician-anesthesiologist. This allows the surgeon to practice careful unhurried surgery free of interruptions, and the patient can be spared unnecessary risks.

(signed) Alfred L. Mauro, M.D.
Chief, Department of Anesthesiology

Correlative Neuroanatomy and Functional Neurology; Head and Spine Imaging; Principles and Practice of Ultrasonography in Obstetrics and Gynecology

Correlative Neuroanatomy and Functional Neurology

Joseph G. Chusid. Los Altos, CA, Lange Medical Publications, 1985. (\$14.50)

This book, first published in 1938, now is presented in its 19th edition and is available in ten different languages. It has been one of the Lange Publication series of large, softcover texts for many years.

Dr. Chusid begins his preface by stating that "this volume is intended for the beginner in clinical neurology." Nevertheless, there are few if any of us who could recite the details of neuroanatomy described concisely in this volume. It is not intended by the author to be any more than a supplement to standard texts. Yet in 20 years of teaching neurology to medical students, residents, and practicing physicians, I never have found any who could not learn a good deal from this book. However, all areas are not considered in equal depth.

The first half of the book deals with various aspects of functional neuroanatomy and physical findings, and is excellent. Some minor recent changes have been made here in the consideration of the skull and spine, and placed in the logical sequence prior to the chapters on brain and spinal cord anatomy. This seems an improvement over prior editions. Some of the sections on diagnostic studies treat these topics fairly superficially. Comments about evoked response testing, nuclear magnetic resonance scanning (magnetic resonance imaging), carotid artery examination by real-time echo and Doppler technique, and digital subtraction angiography need to be introduced or expanded and updated further.

The final segment of this book deals with various neurologic diseases and clinical conditions. Most of these are described only briefly, but a number of excellent charts are provided which are helpful in differential diagnosis and treatment.

In summary, this book remains an ongoing classic and should be explored by every medical student and resident physician. It is intended for use by the beginning student, but holds such a multitude of clear presentations of various topics that graduate physicians always will find it of use. We are indebted to Dr. Chusid for continuing to present new editions of this book. Its reasonable price makes it even more attractive.

Stanley C. Leonberg, Jr., M.D.

Head and Spine Imaging

Carlos F. Gonzalez, Charles B. Grossman, Joseph C. Masden (eds). New York, NY, Wiley Medical Publications, 1985. Pp. 952. (\$150)

The editors' object was to compile an up-to-date review of neuro-radiology including CT, neurosonography, PET, and MRI. Most of this complex but wholly informative text is CT; the other modalities are discussed separately and only briefly.

The book begins with a brief review of the principles of the imaging modalities. Normal anatomy is reviewed by the use of high-quality CT and NMR scans. Pathological aspects of brain and spine scanning each are subdivided into adult and pediatric sections. An in-depth section is devoted to orbital CT and to

temporal bone scanning. A special section on MRI is included; in it, emphasis is placed on the clinical applications.

The chapters contain high-quality CT scans with liberal use of pathological specimens. The text is clearly written; however, the editors apparently assume that the reader has a previous knowledge of neurological disease, and a physician outside this area may have difficulty with terms that are not defined. Still, this text is recommended to the physician with a background in neurological sciences.

Neil B. Horner, M.D.

The Principles and Practice of Ultrasonography in Obstetrics and Gynecology, Third Edition

Roger C. Sanders and A. Everette James, Jr. (eds). Norwalk, CT, Appleton-Century-Crofts, 1985. Pp. 663. (\$75)

The third edition of this well-established text is a commendable compilation of recent advancement in the field of ultrasound, e.g. real time imaging and prenatal diagnosis.

After the beginning chapters briefly outline the physics of ultrasonography with emphasis on its practical application, the text provides a clinical discussion of the applications of Doppler monitoring. A broad range of topics are reviewed, including techniques of prenatal diagnosis of cardiac, thoracic, and cranio-facial anomalies. The well-written chapters each conclude with a concise review, and their scans are of high-resolution quality. Readers will find the chapter on the differential diagnosis of pelvic masses especially informative.

The chapter, "Normal Anatomy of the Female Pelvis: Ultrasound with Computed Tomography Correlation," is a good review of anatomy but should have demonstrated additional CT scans. To its credit, this text succeeds as a synthesis of academic and clinical information and is recommended highly to the physician who seeks a readable and up-to-date reference text.

Neil B. Horner, M.D.

**Drs. Adler; Bensley;
Brower; Chiechi;
Cockburn; Dawson;
Goldberg; Hammell;
Hopping; Peters;
Scranton; Yates**

Dr. Howard E. Adler

A family practitioner in New Brunswick, Howard Edward Adler, M.D., died on August 12, 1985. Born in New York City in 1906, Dr. Adler received his medical degree from Charles University, Prague, Czechoslovakia, in 1931. He was a member of our Middlesex County component, and of the American Medical Association. Board certified in his specialty, Dr. Adler had been affiliated with St. Peter's and Middlesex General Hospitals, New Brunswick, and the Rehabilitation Center, North Brunswick. In 1981, he was a recipient of MSNJ's Golden Merit Award, honoring his 50 years as a physician.

Dr. Maynard G. Bensley

We just have learned of the death on March 23, 1985, at the venerable age of 95, of Maynard Gilmore Bensley, M.D. A native of Buffalo, New York, Dr. Bensley received his medical education at the school of medicine at the University of Buffalo, and was graduated in 1915. He established a practice in obstetrics in Summit where he remained until

his retirement. Dr. Bensley was a member of our Union County component and of the American Medical Association. He had been affiliated with Overlook Hospital, Summit, serving as chief of their department of obstetrics for several years. Dr. Bensley was a Fellow of the American College of Surgeons. In 1965, the Medical Society of New Jersey bestowed upon Dr. Bensley its Golden Merit Award, honoring his 50 years in medicine.

Dr. Francis M. Brower, III

Francis M. Brower, III, M.D., a Woodbury family practitioner, died on August 13, 1985. Born in Philadelphia in 1917, Dr. Brower was graduated from Jefferson Medical College of Philadelphia in 1944. He had been affiliated with Underwood Memorial Hospital, Woodbury, and had served on the Board of Trustees at Jeanes Hospital, Fox Chase, Pennsylvania. A member of our Gloucester County component, and of the American Medical Association, Dr. Brower was a Fellow of the American Academy of Family Practice.

Dr. Michele A. Chiechi

Word has been received of the death on August 29, 1984, of Michele Antonio Chiechi, M.D., at the age of 66. A thoracic and cardiovascular surgeon in East Orange, Dr. Chiechi was a member of our Essex County component, and of the American Medical Association. Born in Italy, Dr. Chiechi received his medical degree from the University of Milan in 1942. In 1955, he emigrated to the United States, becoming an American citizen in 1959. He was a Diplomate in Surgery, Thoracic Surgery, and Cardiovascular Surgery, and a Fellow of the American College of Surgeons, of the American College of Cardiology, and of the American College of Chest Physicians. Dr. Chiechi's list of hospital affiliations was most impressive; it included St. Barnabas Medical Center, Livingston; St. Vincent's Hospital, Montclair; Jersey City Medical Center; Clara Maass Medical Center, Belleville; Saint Mary's Hospital, Orange; and St. Michael's, Columbus Hospital, and University Hospital, Newark. He also was an associate clinical professor of surgery at UMDNJ-New Jersey Medical School, Newark.

Dr. Wilfred P. Cockburn

Wilfred P. Cockburn, M.D., a general practitioner who served at the Veterans Administration Regional Office, Newark, for many years, died on July 22, 1985, at the advanced age of 76. Born in Trinidad, British West Indies, Dr. Cockburn received his medical degree from Howard University College of Medicine, Washington, D.C., in 1944. He was a member of our Union County component and of the American Medical Association. During 1951 and 1952 Dr. Cockburn served in the medical corps of the United States Army, emerging with the rank of captain.

Dr. Percival G. Dawson

A general practitioner and surgeon in Newark prior to his retirement in 1980, Percival Gordon Dawson, M.D., died suddenly on July 17, 1985, at Friday Harbor, Washington, at the age of 80. Born in Asheville, North Carolina, Dr. Dawson received his medical degree from Howard University College of Medicine, Washington, D.C., in 1940. During World War II he served in the Army of the United States as medical officer and general surgeon in the Asiatic Pacific area. For four years following the end of the war, Dr. Dawson served both in Jamaica and the Cayman Islands with the Jamaica, British West Indies Medical Service. He was a member of our Essex County component and of the American Medical Association. During the 30 years Dr. Dawson practiced in the Newark area, he had been affiliated with Presbyterian Hospital in that city.

Dr. Benjamin M. Goldberg

A practicing family physician in Trenton for over 50 years, Benjamin M. Goldberg, M.D., died on August 15, 1985, at Community Memorial Hospital, Toms River. A native of New York City, born in 1899, Dr. Goldberg received his medical degree from the University of Maryland School of Medicine in 1923. He had been a member of our Mercer County component, and of the American Medical Association. Prior to his retirement in 1975 to Island Heights, Dr. Goldberg was credited with delivering over 2,000 babies in the Trenton area. Dr. Goldberg was affiliated with Mercer

Medical Center, Trenton. In 1973, he was a recipient of MSNJ's Golden Merit Award, honoring his 50 years as a physician.

Dr. Frank M. Hammell

Frank Mull Hammell, M.D., family physician in Allentown for many years, died on August 15, 1985. Born in Trenton, Dr. Hammell received his medical degree from the University of Maryland School of Medicine in 1933. He was a member of our Mercer County component, and of the American Medical Association. He had been affiliated with Mercer Medical Center, Trenton. During World War II, Dr. Hammell served in the medical corps of the United States Navy, emerging with the rank of commander.

Dr. Richard A. Hopping

A noted proctologist and surgeon in Livingston, Richard Arundel Hopping, M.D., died in Saint Barnabas Medical Center, Livingston, on August 19, 1985, at the age of 72. A native of Newark, Dr. Hopping was graduated from Long Island College of Medicine in 1939. He was a member of our Essex County component, and of the American Medical Association. Dr. Hopping was a Diplomate in Colon and Rectal Surgery, and a Fellow of the American College of Surgeons and of the American College of Gastroenterology. He had been clinical associate professor of surgery at UMDNJ-New Jersey Medical School. Dr. Hopping had been a president of the medical staff and chief of the proctologic surgery department of Saint Barnabas Medical

Center; and proctological consultant to many area hospitals including Clara Maass Medical Center, Belleville; Presbyterian, St. Michael's, and St. James Hospital, Newark; the Hospital Center at Orange; and The Mountainside Hospital, Montclair. From 1944 to 1946, Dr. Hopping served as chief of proctology at the National Naval Medical Center, Bethesda, Maryland.

Dr. Richard C. Peters

Belatedly, we have learned of the death on May 20, 1985, of Richard Charles Peters, M.D., in Sandwich, Massachusetts. Prior to his retirement in 1971, Dr. Peters was a surgeon who practiced in Plainfield for 40 years. Born in New York City in 1903, he was a graduate of Columbia University College of Physicians and Surgeons in 1930. Dr. Peters was a member of our Union County component and of the American Medical Association. He was a Fellow of the American College of Surgeons and of the American Society of Abdominal Surgeons. Dr. Peters had been affiliated with Muhlenberg Hospital, Plainfield, and had served as chief of staff for five years. In 1980, Dr. Peters received the Medical Society of New Jersey's Golden Merit Award honoring his 50 years of medical practice.

Dr. Charles W. Scranton

A retired general surgeon who practiced in East Orange for many years, Charles Wallace Scranton, M.D., died in Moore Memorial Hospital, Pinehurst, North Carolina, on July 25, 1985, at the remarkable age

of 87. A native of Oxford, New Jersey, Dr. Scranton received his medical degree from Bellevue Medical College, New York City, in 1923. He was a member of our Essex County component and of the American Medical Association. Dr. Scranton was a Fellow of the American College of Surgeons, and prior to his retirement in 1975 had been a member of the staff of Orange Memorial Hospital for 50 years. From 1951 to 1954 he had been chairman of their medical staff. In 1973, Dr. Scranton was a recipient of MSNJ's Golden Merit Award, in recognition of his 50 years in medicine.

Dr. Glen L. Yates

A surgeon in Upper Montclair, Glen Luke Yates, M.D., died at his home on July 19, 1985, at the age of 75. A native of Arkansas, Dr. Yates received his medical degree from the University of Tennessee College of Medicine in 1932. He established his practice, with emphasis on obstetrics and gynecology, in 1933, having become a member of our Essex County component and of the American Medical Association. Dr. Yates was a Fellow of the American College of Surgeons, and had a prestigious list of hospital affiliations, including The Mountainside Hospital, St. Vincent's Hospital, and Community Hospital, all in Montclair; Saint Barnabas Medical Center, Livingston; Presbyterian Hospital, Newark; and East Orange General Hospital. In 1982, Dr. Yates was a recipient of the Medical Society's Golden Merit Award, honoring his 50 years as a physician.

AUTHOR INFORMATION

Style Sheet

New Jersey Medicine is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published in New Jersey Medicine is copyrighted by MSNJ.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

manuscript based on a presentation made in New Jersey.

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SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the

source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

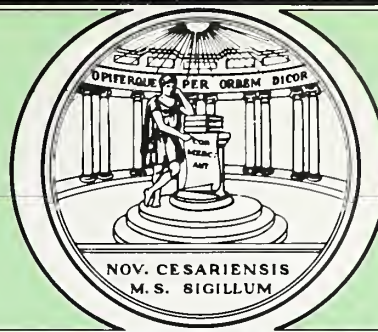
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All communications should be sent to the Editor, *New Jersey Medicine*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

MEMBERSHIP NEWSLETTER



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THE MEDICAL SOCIETY OF NEW JERSEY

VOLUME 28

AMA COMMENTS ON FEDERAL LEGISLATION AND REGULATIONS

H.R. 3505, School Bus Safety Legislation. The AMA informed the sponsor of H.R. 3505 of its policy of support legislation to promote the availability of seat belts in all school buses in the U.S. The bill would require annual inspections for all school buses and seat belts for all buses added to service. (Letter to Representative Lawrence J. Smith, September 12, 1985.)

Physician Credential Verification. AMA Board Chairman William Hotchkiss, M.D., told a House Committee of recent AMA activity involving the verification of the credentials of VA physicians. The AMA Physician Masterfile was utilized to verify VA records of physician education, licensure, and specialty certification. (Testimony before the House Committee on Veterans' Affairs, September 12, 1985.)

Inadequacy of Current Funding for Medicare Carriers. The AMA presented its concerns that funds for Medicare carriers to administer the supplemental medical insurance segment of the Medicare program (part B) during fiscal year 1986 will be inadequate. The AMA said that "the Administration's request for these operations for 1986 is \$920 million, an increase of less than one-half of 1 percent (only .36 percent) over the appropriation for 1985. Not only does this level of increase fail to keep up with the projected increase in the rate of inflation of almost 4.2 percent, it totally fails to respond to increased demands on the Medicare carriers. We are concerned that, with an inadequate level of funding for Medicare carriers, such delay in payments not only will be perpetuated but will increase." (Letter to Senators Proxmire and Weicker, Representatives Conte and Natcher, September 12, 1985.)

NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

In 1974, the AMA correctional health care program expanded into a broad-based coalition of 26 professional associations, with a common interest in correctional health care. The result was the National Commission on Correctional Health Care in 1982.

The primary purpose of the program—accreditation—continued, but the focus expanded to include state prisons and juvenile confinement facilities as well as jails.

The goal of the Commission is to improve health care delivery in the nation's jail, prison, and juvenile confinement facilities through: accrediting facilities which meet minimum health care standards; developing programs for training correctional and health personnel; providing technical assistance; developing and distributing publications and uniform documentation; establishing a clearinghouse of information on correctional health care; convening national conferences and regional and local seminars; and researching selected aspects of correctional health care.

NEW AAMA PRESIDENT

Margaret Corcoran, of Cranbury, was installed as national president of the American Association of Medical Assistants (AAMA). A founder of the Bergen County chapter in 1963, Corcoran was a charter member of the New Jersey State Society of the AAMA. She is a recognized authority on continuing education and accreditation within the medical assisting profession. She served for one year as national vice-president of the AAMA. According to the organization's bylaws, the national vice-president assumes the role of president at the end of her term.

The AAMA is a professional organization comprised of receptionists, clinical assistants, secretaries, technicians, office managers, and related health care specialists who work in physicians' offices and other medical facilities. Headquartered in Chicago, the AAMA includes more than 10,000 members in 47 state societies and 500 local chapters nationwide.

HEALTH CARE OPTIONS

The delivery of health care in the United States is undergoing rapid change. With such choices as private practices, Health Maintenance Organizations (HMOs), walk-in clinics, birthing centers, independent practice

associations, and a diversity of medical specialties, health care providers are competing with each other for patients.

According to most medical leaders, the halcyon days of the past are over. Competition for patients has started the use of marketing techniques to attract and retain patients. Physicians, hospitals, and insurance plans are looking at the patient as a consumer and not a captive audience. Consumer patients can do what every other type of consumer does routinely—shop for the best their available money can buy. Patients are doing this and employers are experimenting with methods to control employee benefit expenses.

Hospitals are using media techniques such as radio, television, newspaper, and glossy magazines to market their services. Hospitals have to sell innovative services as well as good medical care. They are offering low-cost office space to physicians and free wellness clinics to executives of major companies to solicit corporate support—all in an effort to attain and preserve a share of the patient market in order to survive. Hospital occupancy rates fell to 67 percent in 1984, a drop from 72 percent in 1983, according to the American Hospital Association.

DRGs are forcing a decline in hospital stays and admissions. Medicare pays a fixed rate for each illness regardless of how long the patient stays in the hospital or the number of diagnostic tests the physician ordered.

The phasing in of fixed rates has altered the delivery of care. Physicians are being categorized as "Gate Keepers"; previously, they decided when to hospitalize a patient. Today, Health Maintenance Organizations (HMOs) and employers are responsible for deciding when and which hospital a patient may enter.

More than 140 million Americans, or some 60 percent of the general population, are covered by private health insurance, according to the U.S. Census Bureau. Ninety-six percent of workers in medium to large businesses have health insurance according to the Health Insurance Association of America.

There are a number of competing health plans available to consumers. Traditional compensation plans offer a variety of options and deductibles and permit the subscriber to pick the provider. The three largest of these are Blue Cross and Blue Shield, Aetna Standard, and Mutual of Omaha. The traditional plans attract some 80 percent of the health dollars. Most in-

surance consumers remain attached to these plans because it enables them to select the doctor and hospital of their choice.

Prepaid plans charge a fixed fee to cover all medical services given by a selected group of providers. There are three types of Health Maintenance Organizations: (1) Staff Model—clinic site; (2) Closed Panel—see patients in offices; and (3) Individual Practice Association (IPA)—open to most physicians, and patients have a wide selection of doctors. HMOs offer clinic-like settings and specific time allowances for visits. These plans include a large number of para-professionals as staff help who may field routine calls or visits. Some are open round-the-clock and provide satellite clinics for geographic convenience.

The IPA plan has been described as an HMO without walls. It is an association of many private practitioners with an array of specialties who treat patients in their private offices. Patients can receive care from any physician participating in the plan.

The "choice" health care plan is an option halfway between HMOs and IPAs. The provider contracts with a group of primary care physicians who see patients in a private office setting. If the consumer needs hospital care or emergency care, they must go to a choice plan facility.

Marketing has long been recognized as a useful business tool. The medical community has shunned it as unprofessional self-promotion, but as competition for patients increases, physicians are going to have to reconsider their position.

Marketing is a way to focus a medical practice on the patient as a consumer. It involves several steps, such as evaluating the competition, analyzing consumer choices and desires, and developing a strategy that includes services offered, prices charged, and location of services offered.

The single most important marketing tool that is available to the physician is the relationship that the doctor and his staff has with the patient. It is the number one marketing tool.

Patients have a right to be fully knowledgeable about the course of their treatment. Health care providers would do well to examine their patient relationship techniques. Health care consumers have a wide choice of provider services to pick from. Why not take the time and effort to make it easier to select what you have to offer—it's called survival.

Limited Access Ruling and Tort Reform Activity

***Court Gives Plaintiff Limited Access to
Records; Accelerated Tort Reform
Activity***

LIMITED ACCESS

The NJ Supreme Court ruled that in limited instances, the investigative records of a state licensing board may be released to a citizen.

The case concerned a medical malpractice suit in which the patient's estate is seeking information obtained by the State Board of Medical Examiners. The Board obtained the information as part of its investigation into several deaths that occurred in the obstetrics and gynecology unit of a hospital in Newark.

In 1980, a 62-year old woman had gone to the hospital for what was characterized as routine gynecology work, the Court noted. According to the attorney handling her estate, she died in the recovery room after the work was performed.

Under the Court's ruling, written by Justice Daniel O'Hern, her estate is entitled to seek access to portions of the investigative records. The case is in the pretrial stage. O'Hern said, "An applicant seeking the opinions, conclusions, sources of information, and investigative techniques of the agency should demonstrate a need (for the materials) more compelling than the agency's recognized interest in confidentiality."

That interest in confidentiality, he said, is "self-evident." According to O'Hern, "A full and free exchange of discourse would be hampered if the preliminary thought processes of agency members were bared."

He added, however, that "It is equally apparent that the litigant in this case has an extraordinary interest in gaining access to the information. This patient has suffered the ultimate injury, an untimely death."

In the ruling, O'Hern drew a distinction between factual matters investigated by the agency and the opinions and conclusions of the agency regarding its investigation. The agency's opinions and conclusions are more entitled to protection from disclosure than the factual matters are, he said. (*Trentonian*, June 6, 1985)

TORT REFORM ACTIVITY

Heightened efforts by physicians and hospitals to press for tort reforms that hopefully will provide a measure of relief for a fast-deteriorating professional liability climate marked 1985 state legislative sessions. As the campaigns accelerated, trial lawyers in some states dug in their heels to resist the attempts to enact new bills that they claim would undercut patients' constitutional rights to seek redress for injuries sustained while receiving medical care. In at least one state—California—the lawyers threatened to take the issue to the public via an initiative on the ballot next year and have mounted an attack on a comprehensive package of tort reform enacted in that state a decade ago. Recent court decisions upheld four provisions of that legislation and these decisions have incensed lawyers.

It was nearly 10 years ago that the medical community first sought legislative relief for what then was termed a serious national medical malpractice crisis. In a flurry of legislative activity, a number of bills were pushed through in the states, but in the ensuing years, some of these measures have been struck down as unconstitutional. Now, a new so-called "crisis in affordability," coupled with a shrinking insurance capacity in the industry, once again is sending physicians and hospitals back to knock on legislators' doors for tort relief.

A list of tort legislation introduced in current state legislative sessions is shown in the Table. This list includes 126 bills that were introduced; of these, 41 bills were successful. Five legislatures officially have not concluded their current sessions so action still is possible on some measures before year-end 1985. Some bills in states with two-year sessions carry over for action next year.

Three states with serious professional liability problems scored the biggest victories on the legislative side: Florida, Illinois, and New York. In each of these three states, omnibus bills were enacted. Kansas and Utah also made some fairly impressive gains, as did Georgia, Indiana, and Montana.

Most successful were bills to enact a collateral source rule, permitting a mandatory offset of awards of benefits received from other sources; establishment of a sliding scale of attorneys' contingent fees; and establishment of various types of screening panels to review malpractice claims before trial. Least successful were efforts to cap noneconomic damages (Illinois and Kansas were successful here), to modify existing statutes of limitation, or to change the joint and several liability doctrine. (*Medical Liability Monitor*, July/August 1985)

*This item from the Department of Professional Liability Control, MSNJ was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Director of Special Projects.

TABLE

Report on Professional Liability Tort Reform Activity—1985

State	Bills Introduced	Status	Next Legislative Session
Alabama	HB 872—Collateral source rule	Failed	January 1986
	HB 870—\$250,000 cap on noneconomic damages	Failed	
	HB 869—Periodic payments of awards	Failed	
Arizona	SB 1279—Modified statute of limitations	Enacted	January 1986
	SB 1204—Sliding scale of attorneys' contingent fees	Failed	
	SB 1205—No contingent fee on punitive damages	Failed	
	SB 1114—Judge sets punitive damages; paid to state fund	Failed	
	SB 1367—Periodic payments	Failed	
Arkansas	SB 659—Comparative fault bill	Failed	January 1987
	HB 57—Modified statute of limitations Act 894	Enacted	
California	SB 75—Joint and several liability	Passed Senate: Assembly vote	
	SB 520—Seeks repeal of Medical Injury Compensation Reform Act (MICRA)	Carries over as two-year bill	
	SB 514—Raises cap on pain and suffering from \$250,000 to \$1 million	Carries over as two-year bill	
	SB 654—Recovery of costs by prevailing party	Pending	
	SB 840/841—Bifurcation of medical malpractice actions	Unknown	
	AB 2087—Mandatory insurance requirement for physicians and hospitals	Pending	
	AB 1122—Plaintiff must prove punitive damages	Failed	
	AB 2505—Personal Injury Compensation Reform Act (PICRA) extends MICRA provisions to all personal injury cases	Pending	
Colorado	HB 1083—Limits actions against physicians who obtain second opinions	Failed	January 1986
	HB 1231—Comparative negligence bill	Enacted	
	HB 1256—Limits on punitive damages	Failed	
	HB 1319—Permits individual to insure against medical negligence	Failed	
Connecticut	HB 5364—Collateral source rule	Enacted	February 1986
	HB 5360—Cap on pain and suffering damages	Failed	
	HB 5362—Periodic payments	Failed	
	HB 5363—Limits on attorneys' contingent fees	Failed	
	HB 5267—Ad damnum provision	Failed	
	HB 5361—Discourages frivolous suits	Failed	
	HB 5110—\$10,000 for study of medical malpractice problem; report due 2/86	Enacted	

State	Bills Introduced	Status	Next Legislative Session
Florida	SB 325—Attack on three-year statute of limitations for minors	Failed	
	SB 326—Attack on three-year statute of limitations	Failed	
	SB 330—Permits surviving spouse to bring loss of consortium claim in wrongful death action	Failed	
	HB 1352—Omnibus bill includes community standards of care; mandatory periodic payments about \$500,000; 90-day notice of intent to sue; sliding scale of attorneys' contingent fees; "offer of judgment" provision penalizing either side rejecting an offer within \$25,000 of ultimate jury award; arbitration options in cases where defendant admits liability; judge can order nonbinding arbitration in certain cases; peer review immunity; good faith failure to order supplemental diagnostic tests not actionable; mandatory MD insurance requirement; statutory definition of "repeated malpractice" set at three or more claims in five years with settlements/awards of \$10,000 or more per claim; mandatory risk management requirements	Enacted	
Georgia	CSHB 1037—Joint and several liability	Failed	January 1986
	HB 630—Prohibits plaintiff from dismissing and refiling suits, permitted twice under prior statute	Enacted	
	HB 189—Recommends but does not require that judges structure awards	Enacted	
Hawaii	SB 170—Modifies statute of limitations	Enacted	January 1986
	SR 110—Authorizes study by Dept. of Commerce and Consumer Affairs on medical malpractice; report by 1/86	Enacted	
Illinois	**HB 1604—Several bills combined in omnibus package; includes sliding scale of attorneys' contingent fees; requirement for a certificate of merit refiling a suit; established screening panels to review merits of cases; permits periodic payments; abolishes punitive damages; collateral source rule; requires itemized verdicts; provides for early dismissal from suit of uninvolved defendants; sets expert witness requirements; drops requirement for special damages, easing countersuit; requires release of patient	Enacted	January 1986
	HB 1955—Allows medical disciplinary board to require MDs to submit to physical and mental exams if under investigation; provides peer review immunity for MDs involved	Enacted	

**Suit contesting constitutionality of legislation immediately filed after governor signed

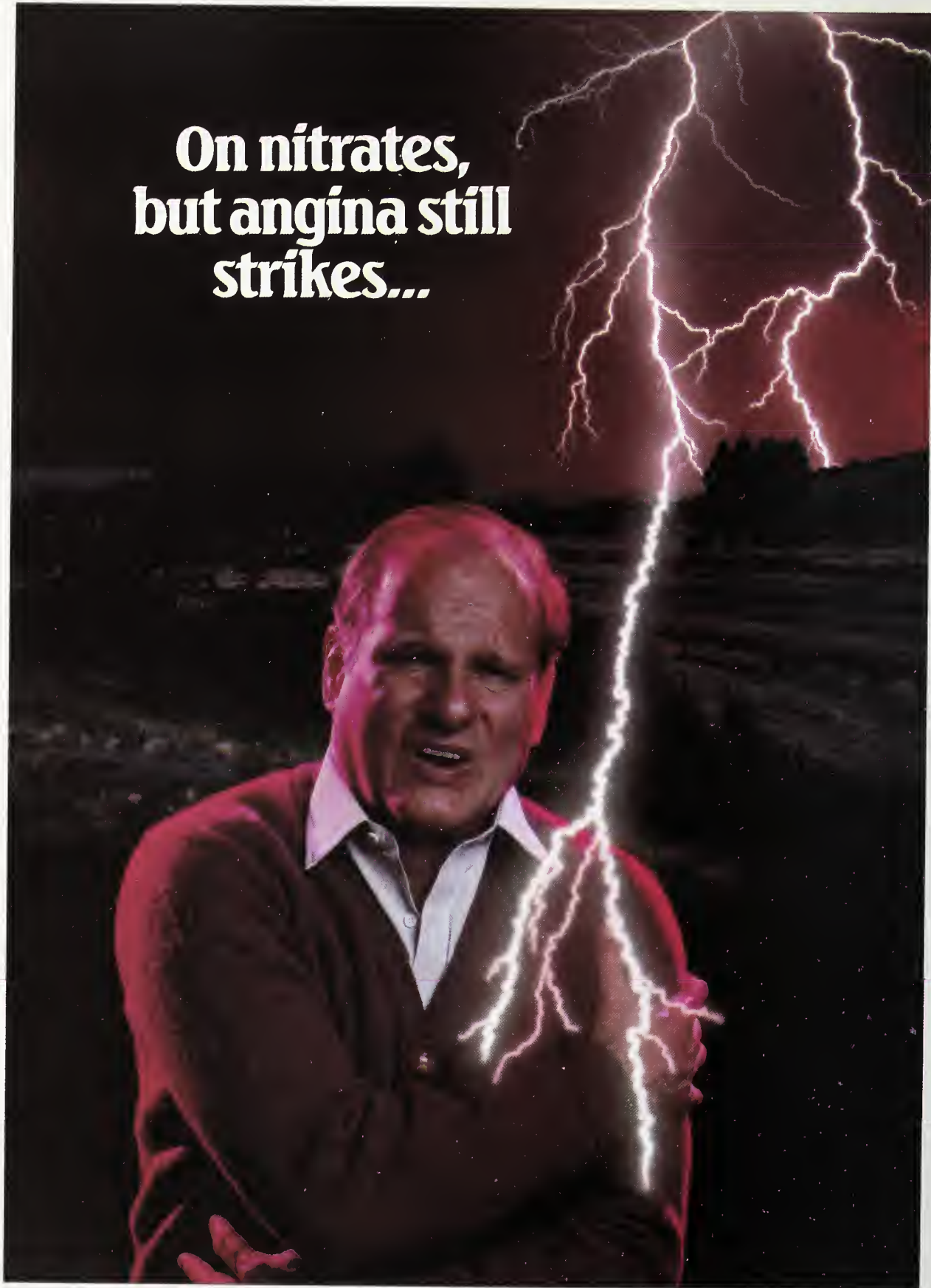
State	Bills Introduced	Status	Next Legislative Session
Indiana	with allegedly incompetent MDs		
	HB 1298—Permits periodic payments for Enrolled awards made by Patient Act 1298 Compensation Fund; allows bypass of screening panel if both parties agree to go directly to court	Enacted	Regular session, January 1986
	House—Permits surcharge for Patient Enrolled Compensation Fund premium to Act 1944 increase 75% immediately, perhaps to 100% January 1988	Enacted	
Iowa	House—Permits periodic payments Enrolled Act 443	Enacted	
	House—Package of several tort reforms, File 655 including limits on noneconomic damages of \$100,000; requirement for pretrial screening panel; authorization of optional arbitration of claims; periodic payments	Failed	January 1986
Kansas	Sub. SB 110—Limits punitive damage awards by a percentage of increase formula and/or a cap of \$3 million; places burden on plaintiff to establish willful or wanton conduct, fraud or malice to obtain punitive damages; requires separate proceeding to set punitive damages; 50% of punitive damages go to state Patient Compensation Fund; collateral source rule	Enacted	January 1986
Louisiana	HB 1704—Extends Louisiana's malpractice Act 239 statute limiting awards to \$500,000 plus future medical benefits to state providers of services to establish parallel public/private statutory framework for handling malpractice settlements/awards	Enacted	April 1986
Maine	LD 528—Sliding scale of attorneys' contingent fees	Withdrawn for rework	January 1986
	LD 543—Losing plaintiffs must post bond for defendant's witness and attorney fees	Withdrawn for rework	
Maryland	SB 16—Proposed changes to streamline pretrial screening panel system	Failed	January 1986
	SB 69—Reorganizes Medical Liability Mutual Liability Insurance Society to permit formation of subsidiaries to sell other insurance lines. Task force established to study malpractice	Enacted	
Massachusetts	S 1746—Increases pretrial bond requirement	All bills pending	January 1986
	S 1765—Sets \$250,000 limit on noneconomic damages		
	S 1070—Collateral source rule		
	S 1069—Expert witness qualifications		
	S 1764—Contingent fee schedules for attorneys' fees		
	S 1766—Modified statute of limitations		

State	Bills Introduced	Status	Next Legislative Session
Minnesota	S 1763—Periodic payments of awards		
	S 918—Immunity for peer review duties		
Mississippi	S 917—Reporting of medical malpractice claims to Board of Medicine		
	S 916—Dedicated funding for Board of Medicine for quality control		
Missouri	Professional liability study underway		February 1986
Mississippi	HB 775/SB 2634—Limits punitive and general damages	Failed	January 1986
	HB 908/SB 2723—Collateral source rule	Failed	
Missouri	SB 7—Collateral source rule	Failed	January 1986
	SB 49—Periodic payments over \$50,000	Failed	
	SB 126—Cap of \$350,000 for noneconomic damages	Failed	
	HB 357—Peer review immunity	Enacted	
Montana	SR 304—Form Senate interim study committee on medical and product liability	Enacted	
	HB 738—Revises operation of pretrial screening panel system	Enacted	January 1987
Nevada	HB 658—Authorizes creation of a standby Joint Underwriting Association if malpractice insurance becomes unavailable. Sunsets in two years	Enacted	
	SB 200—Limits punitive damages	Failed	
Nevada	AB 696—Pretrial screening panels reestablished	Enacted	January 1987
	AB 408—Periodic payments	Failed	
New Hampshire	AB 277—Collateral source rule	Failed	
	AB 490—Limits on attorneys' contingent fees	Failed	
New Hampshire	SB 16—Modified statute of limitations	Passed Senate; House referred to interim study	January 1986
	SB 220—Ad damnum (passed); no res ipsa (action unnecessary; doctrine no longer applied in state); modified state of limitations	Passed Senate; House referred to interim study	
New Jersey	S1112—\$100,000 cap on pain and suffering (A1919)	All bills pending in committee	1985 session ends December; new session, January 1986
	S1135—Collateral source rule; periodic payments (A1918)		
	S1079—Modified statute of limitations (A1921)		
	S1140—Affidavit of expert witness must be filed within 60 days of suit (A1922)		
	A3110—Periodic payments		
New York	SB 5191/A 7367—Several bills combined into governor's package including SB 156 requiring mandatory pretrial conferences; SB 157 on periodic payments; limits for pain and	Enacted	January 1986

State	Bills Introduced	Status	Next Legislative Session
	suffering after first \$100,000; limits on attorneys' contingent fees; collateral source rule; SB 158 on exchange of expert opinions between parties; SB 155 on imposition of costs in frivolous suits; and provisions for quality assurance and risk management, including mandatory hospital programs for identification and prevention of medical injuries. Bill also rolls back an authorized 55% premium increase for New York carriers to about 32% with an additional 40% increase postponed until November 30. In the interim new legislation's effect to be studied		
North Carolina	HB 1088—Proposes panel hearing for persons doing immunizations, such as DPT, in event of claim	Referred to committee; carries to 1986	June 1986
	HB 1205—Freezes insurance rates for MDs who meet certain reporting stipulations	Failed	
	HB 1176—Substitutes comparative fault for contributory negligence in personal injury cases	Failed	
	HB 344—Creates study commission on malpractice; \$100,000 appropriation; reports 1986	Enacted	
North Dakota	HB 1159—Prohibits wrongful birth and wrongful life suits	Enacted	January 1987
	HB 1064—Collateral source rule	Failed	
Oklahoma	HB 1203—Early complete exchange of information between plaintiffs and defendants	Enacted	January 1986
Oregon	HB 2980—Omnibus bill limits general damages, includes collateral source rule; cap on noneconomic damages; equal access to medical records	Sent to interim study committee	January 1987
	SB 547—Access to plaintiff's medical records	Failed	
	SB 548—Relaxes requirements for countersuing	Failed	
	SB 549—Requires affidavit for expert review of care	Failed	
	SB 550—Amends required proof re punitive damages	Failed	
	SB 551—Sets expert witness qualifications	Failed	
	SB 554—Collateral source rule	Failed	
Rhode Island	HB 6515—Expands study commission	Enacted	January 1986
	S 931—Extends reporting deadlines to February 1986 for commission	Enacted	
	HB 6247—Proposed limits on damages with provisions for payment of future medical benefits	Failed	
South Dakota	HB 1164—Removes sunset provision from statute limiting general damages	Enacted	January 1986

State	Bills Introduced	Status	Next Legislative Session
Tennessee	SB 364/HB 256—Comparative negligence	Deferred to 1986 session	January 1986
	SB 343—Prohibits wrongful birth, wrongful life suits	Deferred to 1986 session	
	SB 932/HB 618—Governor's omnibus bill includes collateral source rule; modification of expert testimony groundrules; requires certificate of readiness before suit can proceed; provides immunization immunity	Deferred to 1986 session	
Texas	SB 292/HB 147—Recovery of costs for frivolous suits	Failed	January 1987
	SB 834/HB 1884—Repeals joint and several liability	Failed	
	HB 1883—Provides immunization immunity	Enacted	
	HB 1858—Requires 60-day notice of intent to sue	Failed	
	HB 1869—Collateral source rule	Failed	
Utah	SB 152—Collateral source rule	Enacted	January 1987
	SB 113—Limits on attorneys' contingent fees	Enacted	
	SB 153—Pretrial screening panels/arbitration	Enacted	
	SB 155—Peer review immunity	Enacted	
	SB 184—Periodic payments	Referred to interim study	
Virginia	HJR 209—Extends malpractice study commission	Enacted	January 1986
	HB 1434—Mandates yearly closed claims reports to insurance commissioner	Enacted	
	HB 1353—Modifies statute of limitations	Failed	
	HB 1091—Subrogation permitted when plaintiff reimbursed by third party	Failed	
Washington	HB 965—Waiver of physician-patient privilege	Failed	January 1986
	HB 966—Out-of-court settlements; jury informed	Failed	
	HB 967—Collateral source rule; jury informed	Failed	
	HB 968—Periodic payments	Failed	
West Virginia	HB 1742/SB 348—Creation of 16-member malpractice study commission; periodic payments; \$100,000 cap on pain and suffering awards; modified qualifications for expert witnesses; sliding scale of attorneys' contingent fees; no ad damnum; shortened statute of limitations; collateral source rule; joint and several liability	Commission created in interim committee; other bills failed	January 1986
Wyoming	Interim study committee at work in House and Senate		January 1987

**On nitrates,
but angina still
strikes...**



CHANGING THE RULES ON DYING



The New Jersey Supreme Court's recent decision in the case of Claire C. Conroy significantly broadens its famous Quinlan decision and represents bold advances in the development of legal medicine and health law.¹ But the procedural requirements in arriving at a decision to terminate or withhold medical treatment from a dying patient are confusing and unnecessarily burdensome, and represent a significant intrusion into the physician-patient-family relationship.

The background is the Karen Ann Quinlan case and the State Supreme Court's decision reached in 1976.² In that decision, the Court made two major contributions to the decision-making process regarding withdrawing or withholding medical treatment for a patient in a permanent coma. The Court said that the focus of the decision ought to be on the prognosis of the patient. If the treating physician believes that the patient "is beyond being restored to a cognitive sapient state," then, the locus of decision making resides with the family. If the family requests that life-sustaining equipment be removed so that their loved one may die as a result of the underlying medical condition rather than be maintained in a persistent vegetative state,

then an ethics committee at the hospital may meet to consider the patient's case. If the committee concurs with the prognosis, the Court said, all life-sustaining medical therapy may be discontinued without anyone incurring either civil or criminal liability.

Since 1976, major questions have arisen regarding some of the details of how termination of medical treatment decisions are to be made. For example: Did the Quinlan Court mean all life supports including nutrition and hydration or only medical treatment such as a mechanical ventilator, dialysis, and medications? Did the Quinlan decision extend to patients who were not in a persistent vegetative state or not in a permanent coma? Was there any legally valid distinction between ordinary and extraordinary forms of medical therapy or patient care? Absent specific legislation, would a decision by a patient reached about terminating treatment while legally competent, i.e. a living will, be legally binding when the patient becomes incompetent? The Conroy decision attempts to provide

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By Russell L. McIntyre, Th.D. *

guidance on precisely these questions but, as we shall see, muddies the water and blurs the distinctions as to be judicially and legislatively impractical.

ETHICS COMMITTEES OR GERIATRIC BABY DOE SQUADS?

The Quinlan decision required decision-review by a hospital ethics committee. In 1977, the attorney general and commissioner of health for New Jersey published "Guidelines for Health Care Facilities to Implement Procedures Concerning the Care of Comatose Noncognitive Patients." The guidelines were optional and no institution—hospital or nursing home—was required to form such a committee.³

The Conroy decision, however, assigns no role whatsoever to such an institutional ethics committee. What it does instead is to create a geriatric version of the Baby Doe squads by assigning an investigatory role to the State Office of the Ombudsman whenever a physician or family wants to withhold or withdraw life-sustaining medical therapy from an elderly nursing home patient who is certified to be terminally ill. With full subpoena powers, a team of investigators from Trenton must conduct an official investigation with, according to the Court decision, the presumption that "abuse" of the patient is being committed. "The Ombudsman should treat every notification that life-sustaining treatment will be withheld or withdrawn from an institutionalized, elderly patient as a possible abuse."³

Why the Court ignored the role of the ethics committee is not clear. The Court did recognize that nursing homes are quite different from hospitals. And, in fact, very few nursing homes have established ethics committees. This, however, is not due to the fact that they will not work or are inappropriate in that setting but, rather, that neither the Court nor the state put pressure on nursing homes to form such committees.

As recently as 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research recommended that hospitals throughout the United States establish such committees to decide difficult cases.⁴ The New Jersey experience is being watched closely and replicated in other areas as an appropriate model for ethical decision making in difficult cases.

A survey of New Jersey hospitals published in 1984 by the American Society of Law and Medicine,⁵ reveals that 54 percent of New Jersey hospitals have functioning ethics or prognosis committees with another 12 percent indicating that they would be forming such a committee within the next year.

It is possible that the Court did not realize how well the ethics committee model was working. Instead of assigning the role of reviewing such terminal care decisions to an ethics committee, it has created a very unwelcomed intrusion of an official state investigation into the tragedy that the grieving family already is living through. With the presumption of "abuse," the investigation itself becomes abusive.

The Quinlan decision sought to keep decision making at the local level⁵ and allowed for the unique

sensitivities of the family, physician, hospital, and community to determine what they believed was the most appropriate level of care for that patient. The Conroy decision undermines the effectiveness of this model and creates the presumption that the physician or family is guilty of abuse until they are proved innocent to the Ombudsman.

THE ISSUE OF NUTRITION AND HYDRATION

A second major criticism of the Conroy decision involves the issue of whether the continued feeding of a dying patient always is required or may be optional. A national debate has developed since the murder indictment of two California physicians in the fall of 1983 for removing a nasogastric feeding tube from a terminally ill patient with severe brain damage.⁶ The physicians were indicted for starving their patient to death. The charges subsequently were dismissed but the indictments touch on a sensitive public nerve regarding what minimally is required when we are caring for others.

The Conroy decision states that in the care of the dying patient, feeding either by tube or vein is an artificial means of prolonging life and, as such, is equivalent to a respirator or dialysis and, therefore, can be removed or withheld. The Court used an ends versus means analysis and argued that if the ends were the same, i.e. the artificial prolongation of life or delay of death, then both were unnecessary and not legally required.

While there does not appear to be any good clinical evidence to support the notion that removing nutrition causes a comatose patient to experience increased pain or suffering, there are strong and powerful public sentiments about feeding as part of what minimally is required of us as human beings. This sentiment also is held by a significant number of physicians and was clearly the point made by the New Jersey Appeals Court in its decision in the Conroy case that stated that feeding never was optional.⁸

Law must reflect accepted standards of knowledge as well as be reflective of social attitudes, as long as these attitudes are not unjust. The Conroy decision dismissed this rather profound public sentiment when, in fact, it had another choice.

Claire Conroy was being kept alive by feeding and medications for heart disease, diabetes, and hypertension. The nasogastric tube carried nutrition, hydration, and medications and consistent with Quinlan principles, the Court could have permitted the removal of the medications—which clearly would have allowed her to die from her underlying diseases—yet still have required feeding and hydration for the strong symbolic meaning they have to others: the family, the physicians, and the nursing personnel. When a physician is treating a patient who is dying, he takes on the family as patients. In accepting the death of their loved one, the family's greatest need is to believe that they have done everything medically possible to preserve and extend life, not to be left with guilt feelings for starving their loved one to death. The social and psychological distinction between feeding as a human

Terminal care decision making for elderly nursing home patients in New Jersey has been severely complicated by the recent State Supreme Court decision in the case of Claire C. Conroy.

requirement and all other forms of medical therapy may need to be preserved in the law in deference to our sense of public values.

IN THE PATIENT'S BEST INTEREST

The third major criticism of the Conroy decision concerns the way in which the Court expanded the query to determine what was in the patient's best interest. The Court redefined standard legal categories and came up with a new form of the substitute judgment test which it called the subjective test; and two forms of the best interest test called the limited objective test and the pure objective test.

The Subjective Test. The validity of this test gets its basis from a personal declaration—expressed or implied—that can be attributed to the patient. The most common form of this is the living will in which the patient states that if the time comes that he is terminally ill, can no longer participate in decision making regarding his care, and has lost the ability to benefit from continued medical treatment, he would elect "not to be subjected to resuscitation, surgery, or receive strong antibiotics or other medications" for the sole purpose of postponing death. The patient, on the other hand, requests only to receive pain medication that would make his death more comfortable.

Many states already have passed such legislation making a living will legally binding in those jurisdictions, if properly executed. New Jersey does not have such a statute but the Court was stating clearly that this was an acceptable form of decision making. The Court went on to expand the concept of a living will to include an oral directive conveying the patient's wishes, or the appointment of a proxy through a durable power of attorney.

In addition to a direct written or oral statement, the Conroy Court declared that the patient's authentic wishes also could be deduced from such situations¹ as: 1) the known reaction of the patient to other situations in which a patient was in similar circumstances; 2) the patient's own religious beliefs; and 3) the patient's consistent pattern of conduct and prior decisions about his own medical care.

The Court, however, was concerned about the appropriateness of each of these categories and, therefore, required that all of the above criteria for the subjective test (including the living will) be judged by qualifying standards of remoteness, consistency, thoughtfulness, the maturity of the patient at the time the declaration was made, and specificity. One notes that the subjective test, then in reality, is judged by criteria which are objective and intellectually measurable. And, in this regard, even a signed living will could be disqualified if it failed the Court's measure for being not recent enough, not logically consistent, or not specific enough; to say nothing about how one would judge the patient's thoughtfulness or level of maturity

when the document was issued. The subjective test becomes an objective test and is evaluated by rather precise external criteria.

The Limited Objective Test. When there is no specific declaration by the patient as to what he wants for himself when he cannot participate in medical decisions, either the limited objective test or the pure objective test applies.

The limited objective test may be used, according to the Court, when there is some trustworthy evidence that the patient would have refused the medical treatment. We note that this sounds similar to the subjective test, however, in this case the evidence is too vague to be considered absolute proof.¹ This would include casual or informally expressed statements.

In addition, the decision maker (the Ombudsman) must be satisfied that the burdens of a patient's continued life with the treatment outweigh the benefits of that life for him.¹

The Pure Objective Test. When there is no trustworthy evidence as to what the patient would have wanted, the Court stated that the decision maker (the Ombudsman) must be satisfied that "the net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life."¹ In addition, the recurring, unavoidable pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane. This pure objective test would include the following examples:

1. "Some trustworthy evidence." Who determines and by what criteria?
2. "The burdens of a patient's life with treatment." How do we judge burdens?
3. "Outweigh the benefits of life." How do we evaluate benefits?
4. "Clearly and markedly outweigh."
5. "Inhumane."

The subjective test is to be measured strictly by objective criteria. Now, the so-called objective tests become entirely the subjective determination of the Ombudsman. All of this is to pre-empt the decision making of the family and physician, working through an ethics committee, who would clearly know the patient much more thoroughly and be in a better position to act on behalf of knowledge in his best interest.

CONCLUSIONS

The Conroy decision is a major precedent in determining medical and social responses to patients whose lives are being prolonged artificially by advances in medical technology. It is not the final word, however, and further judicial and legislative refinements are needed to assure that neither patients nor families become victimized by the prolonged use of technology

when all meaningful life is over, or by a bureaucratic system that is insensitive to the tragedies of these families in crisis. A much more rational and effective approach is needed.

First, the use of institutional ethics committees should be required to include patients in all health care facilities, hospitals, and nursing homes. This would insure that the people who are most affected by the decision can share perspectives and insights and come to what they believe is the most ethically appropriate decision.

Secondly, the decision process must be kept at the local level which is less intimidating to a grieving family and caring physicians than an official state investigation, especially one with the presumption of abuse which casts the family in the role of being guilty until proved innocent.

Thirdly, remove the geriatric Baby Doe squad mentality which will have the result that doctors, for fear of liability, will force increased utilization of life-sustaining measures and defensive medicine because they do not want to be involved in or subject the family to a state investigation.

Since the Conroy decision was handed down in January 1985, several key individuals in New Jersey have called upon Governor Kean and the legislature to establish a blue ribbon panel to evaluate the needs of dying patients and their families and to make recommendations on a series of legislative initiatives which would protect the rights of all persons while preserving the state's interest in protecting and preserving life. The panel should include representa-

tives of medicine, nursing, medical ethics, hospital and nursing home administrators, legislators, and citizens. It should have a precise mandate to develop legislative priorities and design model bills to establish legal criteria for brain death, organ donation, treatment of genetically impaired newborns (and diminished seniors), living wills, and the right to forego life-sustaining treatment.

Until this is accomplished, despite the Quinlan and Conroy decisions, the rights of patients and the responsibilities of physicians and health care institutions will remain in confusion and disarray.

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favorable since it suggests that the Conroy decision is a progressive step which would facilitate humane decision making and reflects an increasing societal consensus about how people wish to be treated at the end of life.

THE COURT DECISION

Almost lost in enthusiastic newspaper accounts of the decision, however, were details about the implementation process that the Court would impose in similar future cases. Certainly, very few have had the time or opportunity to read the 100-page Court discussion, but if the Conroy formula is applied broadly, the result is likely to be counterproductive, will make it more difficult to back away from inappropriately active treatment, and may victimize nursing home patients and their families.

Overall, the Court steered adroitly through a maze of potential legal and ethical pitfalls and rendered, in theory, a sensitive and sensible ruling. It accomplished what one expects of good lawyers: review of the appropriate cases and balanced judgment. Unfortunately, they did not stop there but plunged on and became entangled in an area in which they have no expertise.

The first indication of this is seen when, in applying their own formula about how to decide when to withdraw or withhold artificial life support to the specific case of Claire Conroy, the Court was unable to make up its mind. To be sure, all of its questions could not be answered with the available information, but rarely in the real world are the facts as abundant and as clear as they were in the Conroy case. This Court, which would permit humane withdrawal of artificial feeding when life's burdens substantially outweigh its benefits, did not find the family's appeal sufficiently compelling, although the unfortunate Miss Conroy had wasted to a contracted 48 pounds, had a lifelong aversion to medical treatment, had a gangrenous leg, and could respond only to noxious stimuli.

If this case was not persuasive enough—if Claire Conroy was not feeling sufficient physical pain to qualify for the Court's compassion—what case would? The Court held that it would be best to move slowly and to rule only on the specific case before it. In so doing, it created new ambiguity: now, it may be implied that in New Jersey nursing homes, patients no longer can die without a feeding tube in place unless permission is first granted by the state. Once a local decision has been made to withhold or withdraw life support, a cumbersome process must be initiated which includes active participation by the State Office of the Ombudsman for Institutionalized Elderly as well as two deputized physician consultants. Since these watch-

dogs are charged with assuming possible abuse until proved otherwise, inevitably they will introduce a climate of distrust and fear into every nursing home, hardly a desirable mood at a time that calls for exquisite sensitivity.

The reason for the Court's disturbing adaptation of Baby Doe review mentality is its observation that the nursing home industry is historically "troubled and troubling" and that residents uniquely are vulnerable. The Ombudsman's office was created by the legislature in 1978 to serve and protect the needs of the institutionalized elderly and in 1983 this agency was charged with the responsibility of guarding against adult abuse. Although there continue to be serious problems in certain New Jersey nursing homes, this by no means is the case in most and, of itself, is not convincing evidence that an entirely new system of clinical decision making is necessary in nursing homes. Given the same circumstances in a hospital, the Quinlan formula of local concurrence among physicians, family and hospital ethics committee would suffice. Furthermore, contemporary social and economic events are conspiring to move patients from hospitals to nursing homes sooner and sicker, so that the two populations and their problems are becoming more homogeneous.

Although well-meaning, the Court clearly has blundered in confusing the venerable clinical tradition of benign neglect for hopelessly ill patients with negligence and venal exploitation by some unscrupulous nursing home operators. The distinction is crucial and for lack of appreciating that difference, the Court has miscast the Ombudsman's office into a role in which it does not belong. What of a patient with far advanced cancer who lapses into a terminal coma? Lacking affirmation by the Court that in such a case conventional local decision-making processes are still applicable, we are faced with the Orwellian prospect that, henceforth, Big Brother will be a regular partner at the nursing home bedside.

IMPACT OF RULING

The impact of the Court's ruling on medical practice in New Jersey was assessed about one month after the decision, in a poll of 2,200 members of the New Jersey Chapter of the American College of Physicians. The reaction of this group is of particular relevance since it is the internist, more than any other, who cares for this kind of patient. First, the essentials of the Conroy case were described in a newsletter which emphasized the Court's proposed new process of decision making. The results were tabulated from the first 100 responses and are presented in the Table.

Analysis of the replies to the statement about the Ombudsman's role reveals that the only physician who strongly favored the Court's recommendation was an academic cardiologist who has no contact with nursing home patients. Conversely, 33 respondents indicated that they often cared for this category of patients and this subgroup unanimously opposed the Court's plan; 5 disagreed, 29 disagree strongly.

Asked to comment about the likely effect of the Conroy decision, the most frequent replies cited chaos, confusion, increased hospitalization, greater use of feeding tubes, distrust, and noncompliance. The following are three typical responses:

"All extraordinary means will be used to prolong life rather than going through the legal red tape. This will cause much patient suffering and hospital bills."

"Will dilute primary care control and possibly set up a bureaucratic nightmare."

"The suffering of hopelessly ill patients unnecessarily will be prolonged by all means of heroic measures which most physicians will not hesitate to order if the alternative is legal prosecution and/or loss of medical license."

The questionnaire also addressed the related issue of ethics committees which have been suggested by some, including the Medical Society of New Jersey, as a mechanism that should be adapted in nursing homes. The Supreme Court had rejected this approach for nursing home residents like Claire Conroy, but similar cases frequently present comparable dilemmas and distinctions blur. Our questionnaire indicates that nine years after the Quinlan decision first initiated the idea, most New Jersey internists have had only limited experience with hospital ethics committees and most are guarded about their wider application in nursing homes. Many agree that such committees may be helpful in certain complicated cases, particularly by providing a forum when there is some disagreement about how to proceed, but most felt that the committee's role should be limited to that of optional consultants—never as decision makers. There were many comments about the difficulty of promptly convening committees and some noted that even group decision making is not necessarily more respectful of patient rights, nor more sensitive and correct than the judgment of the primary physician and family.

CONCLUSION

It appears likely that the Conroy decision will have a profound impact on how patients are cared for in New Jersey nursing homes but not necessarily in a way that the Supreme Court anticipated. What is most needed at this time is a reaffirmation that the normative process of decision making, both in hospitals and nursing homes, still is based on discussion be-

tween primary physician and appropriate family members of the incompetent patient. Society must clarify what it will tolerate as the limits of acceptable behavior, but should then act to unencumber physicians and families so that they can serve as the advocates of the rights and wishes of those in their care. The entrance of government into this most sensitive area should be deplored. The Ombudsman's office may have a legitimate role in regulating institutions, but this should be limited to cases of crass abandonment or neglect and not to the very different scenario of an anguished family and caring physician consciously attempting to work together toward "the right" decision. Heavyhanded bureaucracy and preconceived assumptions of abuse are repugnant in this latter setting. Ethics committees, although not an ideal solution, as local instruments would be a less odious method of assuring that the proper safeguards of patient autonomy have been respected. However, they should never be cast in the role of substitute decision maker.

We must hope that the state legislature will respond to the Supreme Court's challenge by drafting a broad, compassionate, and pragmatic policy. Rarely has a societal issue demanded such wisdom, tolerance, and good sense.

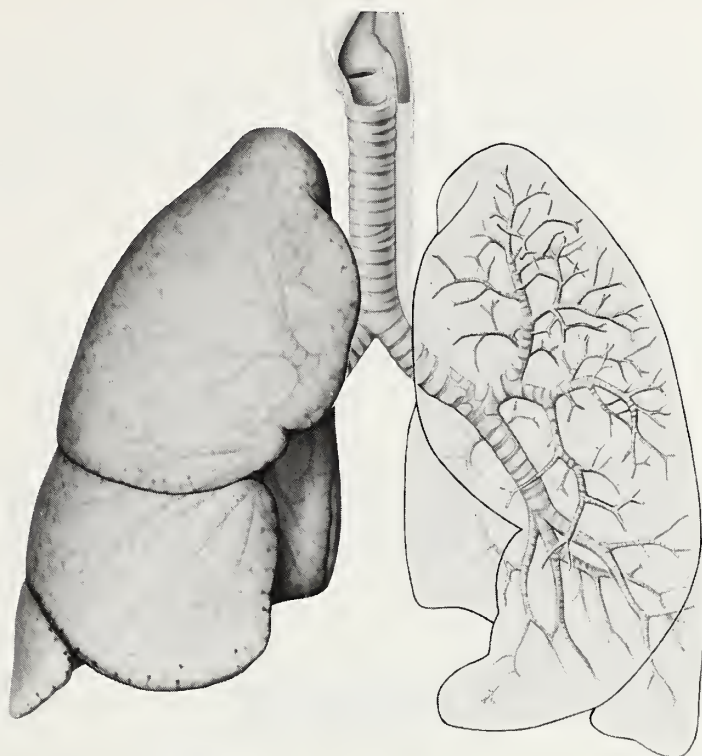
TABLE

RESPONSES TO CONROY DECISION

Agree Strongly	Agree	Unsure	Disagree	Disagree Strongly
1	4	4	31	60
11	15	11	35	28
9	31	8	22	30
5	6	8	33	48

1. It is necessary and desirable to involve the Office of the Ombudsman, as suggested by the Supreme Court, into the decision-making process when artificial life support (including feeding) would be terminated or not initiated in nursing home patients.
2. Historic abuses and special vulnerability of permanent nursing home patients justify that more vigorous scrutiny and a different process of decision making should be used than for similar patients in hospitals.
3. All nursing homes should have ethics committees with representation by a mixed group including lay people.
4. These committees should be involved in individual case management decisions.

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Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cecilor.

Contraindications: Cecilor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cecilor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, manage-

ment should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: **General Precautions**—If an allergic reaction to Cecilor[®] (cefactor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids. Prolonged use of Cecilor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cecilor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cecilor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with ClinTest[®] tablets but not with Tes-Tape[®] (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum

human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cecilor[®] (cefactor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Cecilor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Cecilor is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Cecilor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthralgia/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cecilor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have

occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematologic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 50) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Note: Cecilor[®] (cefactor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients. Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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THE MEANING OF THE CONROY DECISION

The Conroy decision of the Supreme Court of New Jersey¹ overturned a Superior Court Decision² which prohibited the removal of a nasogastric feeding tube from a mentally and physically deteriorated patient in a nursing home in Essex County. The Supreme Court clearly stated that under certain circumstances, life-sustaining medical treatment may be withheld or withdrawn from institutionalized elderly patients. At first blush, it would appear that the Supreme Court's decision constitutes a great victory for the cause of humane and compassionate care: now there is legal and judicial support for the concept of allowing patients to expire gently and naturally, without artificial and extraordinary supportive measures. But as Dr. Russell McIntyre points out, there are some problems with the Conroy decision.

First, the Court specified that its holding is restricted to nursing home residents. I believe that this restriction was unnecessary and is confusing and undesirable. It leaves unresolved the management of the many comparable situations which frequently arise in hospitals or for that matter, outside of institutional settings. (A rational and humane scheme for dealing with some of these problems recently was formulated by a multi-institutional group of physicians; I believe that the recommendations of Wanzer et al.³ might well

serve as a basis for the formulation of policy in this area.)

Secondly, as a guide to making decisions concerning the continuation of life-sustaining treatment, the Court seems to give undue emphasis to the question of pain, and insufficient emphasis to the quality of life. Realistically, it is the quality of life concept which consciously or unconsciously generally governs the perception of families regarding management of the deteriorated and hopelessly ill patient. (The relative irrelevance of the pain criterion is recognized and fully discussed by Justice Handler in his separate opinion⁴ which concurs in part and dissents in part from the Court majority.)

Among the clear and strong affirmations of the Conroy opinion is the rejection as inappropriate of any decision making based on assessment of the personal worth or social utility of an individual's life, or the value of that life to others.

Other important and good features of the Conroy decision are its rejection of any fundamental distinction between ordinary and extraordinary treatment; its rejection of any distinction between the withholding and the withdrawing of life-sustaining treatment; and its rejection of a distinction between the termination of artificial feeding and the termination of other forms of life-sustaining treatment.

By Harvey Rothberg, M.D. *

Given these clarifying and humanistic concepts, one might have expected and hoped that the Conroy decision would simplify and make easier the task of physicians and other caregivers in their efforts to provide the most appropriate and compassionate level of care to deteriorated patients whose medical situation is analogous to that of Miss Conroy. Unfortunately, however, the Court has fabricated a complex and unwieldy mechanism for decision making in such situations, and this is the third and most serious problem area of the Conroy decision.

According to the Conroy judgment, if an elderly nursing home resident is incompetent to make his own decision regarding the withdrawal or withholding of life-sustaining treatment, it is not enough for a guardian or surrogate to act in conjunction with the physician in the patient's best interests, which is what has traditionally been done and continues to be done in nursing homes every week. Now, according to the Supreme Court decision, it first is necessary for the guardian of the patient to notify the Office of the Ombudsman for the Institutionalized Elderly. The Ombudsman is to treat every withdrawal or withholding of treatment as a possible abuse, and is required to investigate the situation promptly. Also, two other physicians not affiliated with either the nursing home or the attending physician must be appointed to confirm the patient's condition and prognosis. After receiving input from these consultants, and with the concurrence of family, Ombudsman, and attending physician, and in the light of the patient's previously expressed wishes (subjective or limited objective tests) or anticipated burdens of life (pure objective test), the guardian then may act to withhold or withdraw life-sustaining treatment.

Having proposed this very complicated procedure, the Court expressed the opinion that in the case of Claire Conroy, the prescribed standards in fact were not met. Nevertheless, the Appellate Court decision prohibiting removal of the nasogastric tube in the case of Miss Conroy was reversed.

The Supreme Court specifically declined to generalize and to set forth guidelines for decision making with respect to life-sustaining treatment in a variety of other situations. Justice Handler, in his separate opinion,⁴ indicated that the Court should formulate a standard that would permit a natural death with dignity and compassion. However, the Court majority expressed the opinion that the legislature was better equipped than the Court to resolve such problems.

CONCLUSIONS

Where does that leave us? I draw four conclusions:

1. In view of the present state of confusion as to what constitutes proper procedure, it is likely to be of real benefit to both patient and physician if the patient has signed a living will proscribing extraordinary treatment in the event of incurable illness. Such a document provides the best possible proof of what the patient would have wanted done, and meets the subjective standard described in the Conroy decision.

2. Physicians must continue to think and act as

responsible and compassionate individuals working actively and effectively to facilitate the best interests of the patients entrusted to their care. Traditionally, medical decisions have been made by sentient and informed patients in conjunction with their physicians. When the patient is unable to participate in the decision, his family ordinarily acts on his behalf in conjunction with the physician. Only when a conflict or disagreement exists between the normally deciding parties should it be necessary to have judicial or other outside intervention. As noted in the Quinlan opinion,⁵ most of the management decisions in the care of sick patients are properly made without involvement of the legal or judicial system. The Quinlan opinion clearly states that "decision making within health care should be controlled primarily within the patient-doctor-family relationship." This has not been changed by the Conroy decision.

3. In view of the Supreme Court's deferring to the legislature for further resolution of the various issues discussed, it is likely that sooner or later the legislature will consider the matter. I agree with Dr. McIntyre and Dr. Nevins as to the desirability of the appointment of a Citizens' Committee to advise the legislature in this area; such a blue ribbon panel should include members of medical and nursing professions as well as hospital and nursing home administrators, citizens, medical ethicists, and clergy.

4. Despite the problems and unresolved dilemmas noted above, the Conroy decision of the New Jersey Supreme Court must be regarded as an important step forward. Even though the detailed procedures are cumbersome and the scope of the opinion is limited, the Supreme Court in its Conroy decision has helped to establish a climate of opinion which emphasizes the best interests of the patient, indirectly implying that a patient's quality of life may be more important than mere respiration and alimentation. This is a favorable development—a step in the right direction. Now it remains for physicians, public officials, and others to go on to develop more workable procedures to deal with the entire range of problems involved in decision making for hopelessly ill patients.

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THE CONROY DECISION



In *re Conroy*, A-108 Sept. Term 1983, decided January 17, 1985. This caption tersely introduces one of the most dramatic medical-legal decisions delivered in the history of New Jersey jurisprudence. The press, including lay, legal, and medical writers, has granted the decision extensive coverage.

As an attorney, I am quite accustomed and generally

sanguine about having the law quoted to me by nonlawyers. The law, after all, is somewhat similar to medicine. Both disciplines directly touch our lives and the experience is not necessarily pleasant. This column will devote itself to the decision the Court delivered and not to speculation regarding future events or imagined inferences.

The nephew of Claire Conroy was her guardian. Mrs.

By Vincent A. Maressa, J.D. *

The author comments on the Court decision regarding Claire Conroy and not on speculation regarding future events or imagined inferences.

Conroy was an incompetent, 84-year-old, bedridden woman with serious and irreversible physical and mental impairments. She resided in a nursing home. She received nutrition and medication through a nasogastric feeding tube. Her nephew sought permission to have the tube removed. Mrs. Conroy's guardian ad litem opposed the request. The trial court granted permission to remove the tube, 188 N.J. Super. 523 (Ch. Div. 1983). An appeal was filed. Before the appeal could be heard, Mrs. Conroy died with the tube still in place. The Appellate Division continued its jurisdiction over the matter and issued a unanimous reversal, 190 N.J. Super. 453 (App. Div. 1983). A petition for certification was granted by the State Supreme Court.

The Supreme Court agonized over the factual complex before it and the potential impact the case would have on society. Ten organizations either intervened or appeared amicus curiae. The written briefs were voluminous. The oral arguments were extensive. The Court pondered the case for over six months and on January 17, 1985, delivered its decision.

The Court began by stating that competent patients generally have the right to accept or refuse treatment for themselves. The right of self-determination usually will outweigh any countervailing interest of the state. The right of self-determination does permit one to refuse treatment even at the risk of death. A competent patient could have chosen to have her nasogastric tube withdrawn.

In reviewing that particular situation before it, the Court held that life-sustaining treatment may be withheld or withdrawn from elderly, incompetent nursing home residents with severe and permanent mental and physical impairment when it is clear the particular patient would have refused the treatment under the circumstances involved. A surrogate decision maker (guardian) is not to choose what a reasonable person would have chosen under the circumstances, but what the particular patient would have done if able to exercise judgment. The patient could have expressed an opinion in a "living will" or some other writing, or verbally to friends, relatives, or health care providers. In this instance, medical evidence that the patient has a limited prognosis is an essential prerequisite, i.e. life expectancy should be one

year or less. Given these guides in a subjective situation, the guardian-surrogate decision-maker could opt to discontinue treatment.

Again, viewing the same type of patient, the Court determined that if either of two "best interests" tests are satisfied, treatment can be withdrawn. The first of these is the limited objective test where there is some trustworthy evidence the patient would have refused treatment and it merely would prolong her suffering. The second of these is the purely objective test. In this instance, there is no evidence of the expressed wishes of the patient but continuation of the treatment would be inhumane.

Whether the test is subjective, limited objective, or fully objective, the guardian of an incompetent nursing home patient must notify the Ombudsman for the Institutionalized Elderly of his intention. The Ombudsman is to review the evidence submitted by the attending physician. Two other physicians, unaffiliated with the nursing home and the attending physician, are to be appointed by the Ombudsman to confirm the patient's condition and prognosis. If the Ombudsman chooses not to act, an application may be made to the Superior Court for the appointment of the two reviewing physicians. If the two physicians concur with the attending physician as to the condition and prognosis, the guardian may request the attending physician to withdraw or withhold the treatment based on the expressed clear intent of the patient, i.e. subjective tests having been met. The Ombudsman must concur in that decision.

If the limited objective or purely objective tests are used in addition to the above review process, family concurrence must be obtained. If there is disagreement, the matter may be resolved by the Court.

If the participants act in good faith in the decision-making procedures set forth in the opinion, they shall be immune from civil and criminal liability involving their role in those proceedings.

In closing its discussion of the case, the Court emphasized that the decision is limited to the incompetent nursing home patient with a limited prognosis. The Court noted that other situations do exist, but they are to be resolved by the legislature.

*Mr. Maressa is the Executive Director of MSNJ.



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TRANSURETHRAL PROSTATECTOMY: ANALYSIS IN A COMMUNITY HOSPITAL

PHILIP S. AFFUSO, M.D., TEANECK*

Analysis of 200 transurethral prostatectomies revealed minimal mortality and morbidity despite the fact that the average patient was 70 years old. Large gland resections, prolonged operative time, and azotemia due to intrinsic renal disease are risk factors.

Prostatectomy, one of the most common surgical procedures performed in a community hospital, can be traced back to the early part of this century. Improved surgical technique and perioperative care have minimized the risk of mortality and morbidity.

METHOD OF STUDY AND RESULTS

I reviewed the hospital charts of 200 patients who had transurethral prostatectomy performed by five attending urologists. Each chart was evaluated with respect to age, symptoms, renal function, presence or absence of infection, pathology, type of anesthesia, necessity for blood transfusions, immediate post-operative complications, length of stay, size of prostate removed, and length of operating time.

Twenty percent of patients had acute urinary retention, while the remaining patients had varying degrees of obstructive uropathy.

Infection was uncommon; only 10 percent of patients had infection as documented by a positive urine culture and none had sepsis.

Fifteen percent of our patients exhibited renal insufficiency secondary to such intrinsic renal diseases as diabetic nephropathy and nephrosclerosis. Obstructive uropathy was not a cause of renal failure in any of our patients.

The average age in this series was 70 years with a

range of 52 to 97. Approximately half of all complications occurred in those patients over the age of 70, which is in keeping with the findings of other investigators.⁶ Eighty percent of our patients had benign prostatic hypertrophy, while the remainder had adenocarcinoma. Approximately 50 percent of patients had regional anesthesia and the remainder had general anesthesia. No relationship could be documented between the type of anesthesia and risk of morbidity and mortality. As would be expected, blood loss increased with the length and size of the resection. Fourteen percent of patients required blood transfusions. Twenty percent required one to two units of packed cells, while the remainder required two to six units of packed cells.

The average length of stay was nine days, which compared favorably to other series.⁶ The average operating time was 70 minutes. In the past, most surgeons would restrict their resection to 60 minutes, noting that beyond this time mortality and morbidity rose.^{2,5} The average weight of tissue resected was 30 g with a range of 15 to 50 g for most patients.

One patient died in the postoperative period from complications secondary to chronic renal failure. This represents a mortality rate of .5 percent.⁴ The remain-

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ing complications are: myocardial infarction (one case); congestive heart failure (two cases); pulmonary emboli (two cases); phlebitis (one case); pneumonia (one case); gastrointestinal hemorrhage (one case); postoperative hemorrhage (two cases); and inability to void requiring second-stage procedure (three cases).

There were 13 complications for a morbidity rate of 7 percent. Past series have recorded morbidity rates as high as 18 percent.²

DISCUSSION

An evaluation has been presented of 200 transurethral prostatectomies with respect to morbidity and mortality. Factors which directly influence morbidity and mortality are renal insufficiency, patient age, prolonged resection (greater than 150 minutes), and size of tissue removed.

Renal insufficiency has been documented to be the most significant factor influencing mortality and morbidity.² The increased need for blood replacement and the propensity towards infection are two specific reasons for the azotemic patient to develop postoperative complications. Our only mortality occurred in an azotemic patient. The terminal event was cardiac failure. A second patient with renal failure developed cardiac failure which responded to vigorous diuretic therapy.

Prolonged resection, usually is related to the size of the tissue removed. It has been documented that resections which extend beyond 60 minutes have a greater number of postoperative complications.⁵ However,

with improved techniques, resection time safely can be extended to 150 minutes; beyond this time, mortality and morbidity rise dramatically.¹

Lengthy resections usually are the result of large prostate glands, i.e. 60 g or more. Therefore, when resected tissue exceeds 60 g to 80 g, the risk of operative and postoperative complications rises dramatically. Twenty percent of all our postoperative complications occurred in those cases where more than 60 g of tissue was removed or where the length of resection time extended beyond 150 minutes.

CONCLUSION

Transurethral prostatectomy is a procedure which is well tolerated despite the fact that it is performed on a patient population of advanced age. The risk factors are described.

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CASE REPORT: MYELOLIPOMA OF THE ADRENAL GLAND

STEVEN ALEXANDER, M.D., AND MENDLEY A. WULFSOHN, M.D., CLIFTON*

Myelolipoma of the adrenal gland is a benign, nonfunctioning tumor discovered at autopsy examination. Large tumors may require surgical excision to relieve symptoms produced by pressure on surrounding structures. Radiological assessment, including computerized axial tomography, is indicated.

Myelolipoma of the adrenal gland is a rare, nonfunctioning tumor consisting of both hematopoietic and adipose tissue. Over 96 percent of the reported cases of adrenal myelolipoma are found incidentally at autopsy; approximately 50 percent of these cases were microscopic findings.¹ We report a case of an adrenal myelolipoma which was removed surgically.

CASE REPORT

Our patient was a 67-year-old male admitted into Beth Israel Hospital, Passaic, because of acute urinary retention and right flank pain. His significant past medical history included diabetes mellitus, hypertension, and arteriosclerotic heart disease. Coronary artery bypass surgery was performed two years previously.

The salient physical finding was tenderness in the right flank area; there was no palpable mass. The prostate gland was enlarged, smooth, and well demarcated.

Urinalysis disclosed 8 to 10 WBC/HPF, but no red blood cells in the urinary sediment. BUN was 36 mg/dl and creatinine was 1.7 mg/dl. The sedimentation rate was 105. Serum cortisol and urinary 17 hydroxy steroids, and metanephrine levels were within normal limits. The remainder of the laboratory examination was normal.

Intravenous urography demonstrated bilateral renal

function. There was downward displacement of the right kidney suggestive of an adrenal mass (Figure 1). Ultrasonography showed the presence of a highly echogenic mass above the kidney (Figure 2).

Selective right renal arteriography demonstrated the presence of a large adrenal mass with minimal vascularity (Figure 3). There was draping of the adrenal vessels around the mass. An inferior vena cavagram showed no abnormality (Figure 4).

Computerized axial tomography showed a large encapsulated retroperitoneal mass of low mottled density with an attenuation value of -80 located in the right adrenal area (Figure 5). There was no associated lymphadenopathy or invasion into adjacent organs.

Surgical exploration revealed a large yellow, smooth mass above the right kidney. The adrenal vein was ligated and the mass was separated easily from the surrounding structure and removed. The patient had a satisfactory recovery. A transurethral prostatectomy was carried out for benign prostatic hypertrophy ten days later.

PATHOLOGY

The mass was soft and globular; it weighed 425 g and measured 14 x 13 x 6 cm (Figure 6). The external

*Drs. Alexander and Wulfsohn are Attending Urologists, Beth Israel Hospital, Passaic. Correspondence may be addressed to Dr. Alexander, 1100 Clifton Avenue, Clifton, NJ 07013.



Figure 1—Downward displacement of right kidney suggestive of adrenal mass.

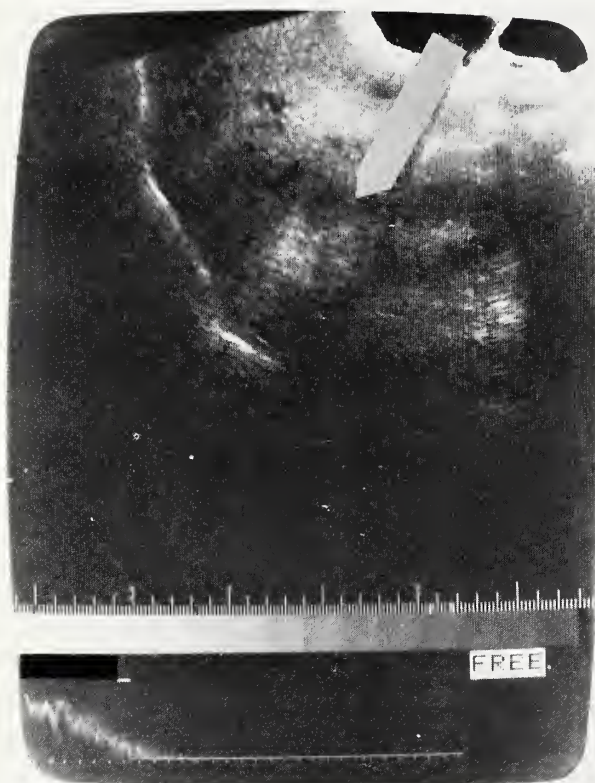


Figure 2—Ultrasonography shows presence of highly echogenic mass above kidney.

surface was yellowish-gray in color and lobulated with some local areas of congestion. A portion of the adrenal gland was present. The cut surface was lobulated, finely granular, and yellowish-gray in color with a few fibrous septa. The tumor was well-encapsulated involving the outer layer of the adrenal cortex. The medulla was gray and compressed.

The microscopic examination revealed adult adipose tissue with foci of active bone marrow elements; namely normoblasts, granulocytes, and megakaryocytes. There was no evidence of adrenal hyperplasia (Figure 7).

DISCUSSION

This uncommon generally asymptomatic tumor

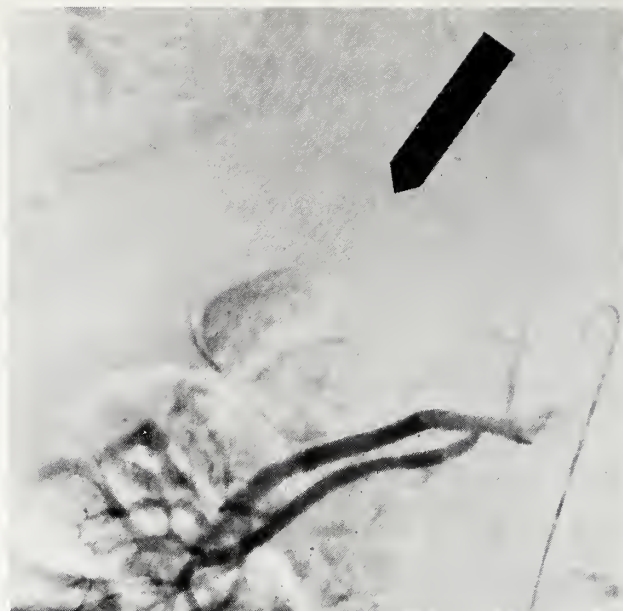


Figure 3—Selective right renal arteriography shows the presence of large adrenal mass with minimal vascularity.



Figure 4—Draping of the adrenal vessels around the mass.

usually is discovered at postmortem examination. It most often occurs on the right side in men in the fifth to seventh decade of life. Malaise, abdominal discomfort, and anorexia may be present, but abdominal pain may occur if a large tumor is present. Hemorrhage from a myelolipoma can produce a retroperitoneal hematoma.

Myelolipoma has been reported to occur in patients with multiple hemangiomas in the liver and spine. Extra-adrenal myelolipoma may reside in the retroperitoneum and posterior mediastinum. Pseudohermaphroditism, intersex, virilism, Addison's disease, and Cushing's syndrome have been reported with adrenal myelolipoma.^{2,3}

Surgical excision of the tumor is indicated for relief of symptoms and confirmation of the diagnosis. The first adrenal myelolipoma which was excised surgically occurred in 1957,⁴ but since then reports of surgically resected tumors have been published. Pain was the presenting symptom in 14 patients.



Figure 5—Computerized axial tomography shows large encapsulated retroperitoneal mass of low mottled density with an attenuation value of -80 in right adrenal area.

RADIOLOGICAL ASSESSMENT

A plain abdominal x-ray film may demonstrate a relative translucency in the suprarenal areas. Intravenous urography with tomography is normal, unless the kidneys are displaced or compressed by the adrenal mass. Ultrasonography will confirm the presence of a highly echogenic (fat) suprarenal mass; this should differentiate it from cystic lesions of the adrenal gland.

Computerized axial tomography can be highly suggestive of a myelolipoma, especially if the lipomatous element predominates. The density varies from -70 to -115 Hounsfield units with no enhancement of the mass following the administration of contrast media. However, the CT scan may not be diagnostic if the tumor has a dominant myeloid element, hemorrhage into the tumor or calcification also will obscure the diagnosis.^{5,6} Angiography may aid in recognizing the adrenal mass because of vascular specificity.

The differential diagnosis includes retroperitoneal lipoma, retroperitoneal liposarcoma, and renal angiomyolipoma.

Careful assessment of adrenal masses is essential because a preoperative diagnosis of a myelolipoma of the adrenal gland may avoid surgery in asymptomatic patients.

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Figure 6—Gross specimen is a globular soft mass weighing 426 g.

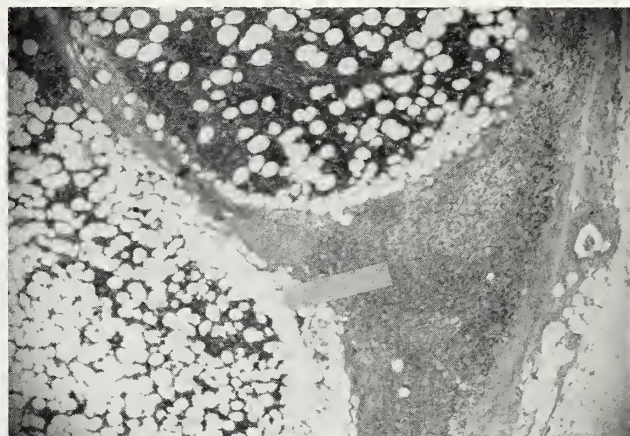


Figure 7—Microscopic examination revealed adult adipose tissue with foci of active bone marrow elements: normoblast, granulocytes, and megakaryocytes.

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UMDNJ Notes

**Stanley S. Bergen, Jr., M.D.
President**

During the past decade, there has been an increasing public awareness and concern about environmental issues, such as hazardous waste, air quality, dioxin, radon, and chemical residues in food and contaminated wells. This public interest and anxiety particularly is acute in New Jersey—the most densely industrialized state in the nation.

Our state has major and justifiable concerns about the quality of its environment. At the same time, New Jersey plays host to a chemical-petrochemical-pharmaceutical industry second to none, and the concerns of these industries, as well as the public anxiety, must be addressed and balanced in a rational and health conscious manner.

The University of Medicine and Dentistry of New Jersey is ready to do just that, by investigating the nature and extent of environmental health problems and to begin developing the solutions which must be implemented over the next decade. Along these lines, I am happy

to announce that, in concert with Rutgers University, we have started the planning process for an ambitious and critically important project—the establishment of an Environmental Health Sciences Institute.

Under the direction of Dr. Bernard J. Goldstein, who recently returned to UMDNJ after two years with the federal Environmental Protection Agency (EPA) in Washington, this Institute will serve as a focal point, allowing researchers to tackle problems as a group that would lie outside the realm of possibility for individual investigators.

Although the mechanisms exist in state government for tackling these problems one by one as they arise, the proposed Institute represents a commitment to a systematic, multidisciplinary investigation to prevent exposures, to understand their consequences, and to improve health.

The Institute will concentrate efforts in environmental health and toxicology, occupational medicine, a new program in exposure assessment, and graduate programs in public health and toxicology.

Specific objectives include:

- Researching the basic mechanisms by which environmental exposures harm the body.
- Examining methods for reducing exposure and improving health.
- Investigating improved ways of communicating information to the public and the government.
- Educating medical students, residents, graduate students in environmental health, occupational health, and risk assessment.
- Educating the public to form informed perspectives about environmental hazards, community and individual risks, and on the potential and actual costs and benefits of our chemical era.
- Serving the community, employers, and the state in all areas of occupational and environmental health, toxicology and risk assessment.

Through its activities, the Institute will attack directly and solve problems of particular importance to the state and to its citizens; will provide an unbiased source of expertise to serve as a resource for the public and for societal decision makers responsible for solving the problems related to environmental health; and will become a financial

asset to New Jersey, both directly, through its ability to attract federal research funds for studies of this national problem, and indirectly, through its ability to make New Jersey more attractive to industry and families, by counteracting the image that New Jersey is an unhealthy place to live.

AMNJ Report

**Dennis R. Filippone, M.D.
President**

Over 40 speakers will participate in the Academy's Annual Internal Medicine Review Course scheduled to begin on Wednesday, January 15, 1986, and run for 19 successive Wednesdays from 4:00 to 7:00 P.M. The course will be held at the Middlesex General-University Hospital, New Brunswick, and marks the first time the course will be held in central New Jersey.

The course is designed to provide a comprehensive review of contemporary concepts in internal medicine. It is designed for practicing internists and family practitioners and will be useful for residents. Extensive syllabus material presently is being compiled for each of the 11 sections and will be presented to each participant at registration.

During the month of November we had two major symposia: on November 2, 1985, the Academy presented, in cooperation with Alexian Brothers Hospital, a "Symposium on Reperfusion (Acute Myocardial Infarction)." The symposium reviewed three approaches in limiting or preventing acute myocardial infarction by dissolving or removing clots in coronary arteries; Dr. William Ganz from UCLA and Dr. Thomas Fogarty from Stanford were among the distinguished faculty. On November 6, 1985, the Academy presented, in cooperation with Somerset Medical Center, a "Symposium on Stress Management for Physicians." The meeting was designed to acquaint practicing physicians with contemporary clinical and therapeutic (including medications) modalities in stress management.

The topic for the Academy's First Wednesday program for November was "The Regional Health Planning Process: Certificate of Need, Competition v Regulation, and High Technology." Our guest speaker was Mr. Martin Parker, Executive Direc-

tor of the Regional Health Planning Council which is the HSA Region 2. Mr. Parker is a veteran of the health planning process having spent over 15 years with the Regional Council. Among his comments, he addressed the decision-making process as it relates to accessibility, cost, and quality of high-technology medical services.

The Annual Awards Dinner of the Academy will be held on Wednesday, May 28, 1986, at the Chanticleer in Short Hills. Our Committee on Awards and Special Events presently is accepting recommendations for candidates for our two awards. A curriculum vitae of the candidate should be sent, accompanied by a letter explaining, in as much detail as possible, the reasons for the nomination. The recipients will be announced by our Board of Trustees after our January 1986 Board meeting.

Current Legislation

The Board of Trustees of the Medical Society of New Jersey approved the recommended positions on the following bills of medical interest:

S-2711-Hagedorn—Termination of Pregnancy. Requires a second physician to be present at any termination of pregnancy procedure if the attending has determined the unborn fetus is 24 weeks of age or older. The second physician is to provide immediate care to the child if it is born alive. **Active Opposition**, it is impossible to implement the requirements of this legislation because of the U.S. Supreme Court constraints and the limits of science.

S-2712-Hagedorn—Fetal Viability. Requires the State Board of Medical Examiners to conduct a study as to when fetal viability occurs so that the conduct of physicians may be governed accordingly. Having conducted such a study, the Board is to promulgate guidelines regarding the termination of pregnancy. **Active Opposition**, because the State Board of Medical Examiners is not a scientific research organization and is incapable of conducting the study in question.

S-2740-Bassano—Certificate of Need (cardiac surgical centers). Deletes the requirement of a certificate of need for cardiac surgical centers. The hospital still would have to comply with Department of Health rules and regulations governing these units. **Active Support.**

S-2754-Bubba—No-Fault. Auto insurers who fail to respond promptly with personal injury protection (PIP) benefits would be subject to punitive damages. **Approved.**

S-2775-Rand—Cancer Research. Authorizes the Commission on Cancer to

establish a nonprofit corporation to solicit and disburse research funds within the state. **No Action.**

S-2781-Russo—Legal and Ethical Medical Problems. Establishes a Commission on Legal and Ethical Problems in the Delivery of Health Care. The Commission is charged with the responsibility of conducting a scholarly and comprehensive examination of the impact of technology on decision making. It shall issue periodic reports to the governor and the legislature. It would consist of 26 members: 9 members from the government, 9 from health-related fields, 5 from general public, and a designated representative from the NJHA, the NJ State Nurses Association, and the NJ Association of Health Care Facilities. **Approved.**

S-2875-Codey—Children's Hospital. Requires the Commissioner of Health to designate Children's Hospital in Newark as the state's specialty acute care children's hospital. Further directs the Commissioner to provide adequate reimbursement rates. **No Action, Law c.306 (1985).**

S-2882-Orechio—Mental Health Planning. Establishes a 21-member Mental Health Care Services Planning Commission to provide a comprehensive plan for all mental health care services for the next decade. Seven of the members would come from the government, the remaining 14 would come from the public. **Conditional Approval**, pending the appointment of at least two physicians to serve on the Commission.

S-2889-Costa—Public Health. Requires a notice to the public by retail food stores and restaurants if sulfites are added to foods being sold by them. **Conditional Approval**, pending an amendment to the bill that would include hair dressing and cosmetic industry notification as well as restaurants.

S-2902-DiFrancesco—Teenage Pregnancy. Establishes, within the Department of Human Services, a residential pilot program for unwed pregnant teenagers and unwed teenage mothers and their babies. **No Action.**

S-2903-DiFrancesco—Maternal Care. Creates a commission to study the

need for residential facilities for unwed pregnant teenagers and unwed teenage mothers and their babies. **No Action.**

S-2905-DiFrancesco—Health Education. Requires the State Department of Education to study and prepare a report for the legislature and governor regarding education to prevent adolescent pregnancies. **Approved.**

S-2922-Hagedorn—Medicaid. Creates a commission to study the adequacy of rates allowed for nursing homes and the quality of care rendered to patients in nursing homes. **Active Support.**

S-2954-Bassano—Pertussis Vaccine—Public Health. Requires the Department of Health to make available to physicians a pamphlet for the adverse effects and benefits of pertussis vaccination. The physician is to maintain appropriate documentation as to vaccination and consent. Major adverse reactions are to be reported to the manufacturer. **Action Deferred**, pending further information from the New Jersey Chapter of the American Academy of Pediatrics.

S-2992-Hagedorn—Microwave Safety. Creates a task force to study the health implication on microwave transmissions. **Approved.**

A-3254-Muziani—Determination of Fetal Viability. Directs the State Board of Medical Examiners to conduct a scientific study to determine when fetal viability occurs. **Active Opposition**, because the State Board of Medical Examiners is not a scientific research organization and is incapable of conducting the study in question.

A-3255-Muziani—Termination of Pregnancy. Requires a second physician to be present whenever a physician terminates a pregnancy involving a live fetus of 24 weeks of age or older. **Active Opposition**, it is impossible to implement the requirements of this legislation because of U.S. Supreme Court constraints and the limits of science.

A-3264-Walker—Health Education. Establishes a toll-free telephone information service for New Jersey residents to advise them on the availability of prenatal, perinatal, and postpartum care

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in the state through the Department of Health. The Department is to maintain an updated directory on maternal services and to market the availability of its information and directory service. **Action Deferred**, pending further information from MSNJ's Committee on Maternal and Child Care.

A-3273-Muhler—Nutritionists. Provides for the licensing of nutritionists and the regulation of their practice. Creates a separate board within the Division of Consumer Affairs with nine members; one of whom shall be a licensed physician. **Disapproved**, because there has been no demonstration that licensing these Boards would have an impact in the public health, also there are other means available through existing state agencies to regulate dangerous concepts such as the treatment of cancer by nutrition and exercise.

A-3292-Ford—Catastrophic Illness in Children. Appropriates 10 million dollars to operate a catastrophic relief fund commission within the Department of Health. The fund is to be used to offset the expenses of catastrophic illness to children. The Commissioner of Health shall be chairman and chief executive officer of the commission. **Action Deferred**, pending further information from the New Jersey Chapter of the American Academy of Pediatrics.

A-3295-Perun—Children's Counseling. Requires the Department of Human Services to establish a network of counseling centers to provide support services to children who have been sexually abused. **Action Deferred**, pending further information from MSNJ's Council on Mental Health and the New Jersey Chapter of the American Academy of Pediatrics.

A-3316-Karcher—Commission to Study Legal and Ethical Problems in Health Care. Establishes a Commission on Legal and Ethical Problems in the Delivery of Health Care. The Commission is charged with the responsibility of conducting a scholarly and comprehensive examination of the impact of technology on decision making. It shall issue periodic reports to the governor and the legislature. It would consist of 26 members: 9 members will come from the government; 9 from the health-related fields; 5 from the general public; and a designated representative from the NJHA, the NJ State Nurses Association, and the NJ Association of Health Care Facilities. This bill is the same as S-2781 (Russo) except it adds the Commissioner of Community Affairs to the Commission. **Approved.**

A-3321-Kline—Nursing Home Employees. Provides for a state and federal criminal history check of nursing home employees. The nursing home is granted

discretion in evaluating the reports and determining the employee's status. **Approved.**

A-3397-Bocchini—Mobile Intensive Care. Allows an emergency medical technician to serve on a mobile unit in place of a paramedic or a registered nurse. **Active Opposition**, this would lower the quality of care available to seriously ill patients. There is no evidence that qualified paramedics and registered nurses are not available for service on mobile units. Patients being serviced by a Mobile Intensive Care Unit are critically ill and should be treated by paramedics or registered nurses until transported to a receiving hospital.

A-3421-Miller—Public Health. Requires public eating places to post notices if their food contains sulfites. **Conditional Approval**, pending an amendment to the bill that would include hair dressing and cosmetic industry notification as well as restaurants.

A-3469-Kern—Health Planning. Provides for local planning councils to replace the health systems agencies. These would be funded by an assessment levied against all New Jersey hospitals. **Active Opposition**, the regulated planning system in New Jersey and nationally has failed to achieve its designated goals. The withdrawal of federal funds means the system should be phased out and not

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made a financial burden to the people using New Jersey hospitals.

A-3470-Kern—Health Care Facilities. Strengthens the control of the Department of Health over health care facilities in issues related to patient safety. **No Action.**

S-3474-Haytaian—Health Care Facilities Improvement Fund. This bill amends existing law to provide that penalties collected for violations of regulations pertaining to patient care in health care facilities or for hazardous or unsafe conditions in these facilities shall be paid into a special fund to be known as the "Health Care Facilities Improvement Fund." Money from this fund shall be used by the Department of Health to remedy life-threatening conditions in health care facilities where the owner or operator is unwilling or unable to do so. It also provides that the owner of a facility must repay the fund with interest or the Department of Health shall have a lien against any facility it repairs for the cost of the repairs and for expenses incurred in placing the lien. There is appropriated \$75,000 to start up the fund. It is the purpose of this bill to ensure that no health care facility in this state shall operate with conditions which pose a threat to the life of any person. **No Action.**

A-3498—Prescriptions. Deletes the requirement of placing the prescribers' registry number on prescription labels. **Approved.**

A-3507—Girgenti-Abuse of the Elderly. Makes it a disorderly persons offense for failure to report instances of abuse to the elderly to the State Ombudsman. **No Action.**

A-3551-Kalik—Child Abuse. Requires boards of education to establish awareness and training programs for teachers on the detection of and response to instances of child abuse. **Approved.**

A-3558-Kosco—Certificate of Need. Creates a Commission to study the certificate of need process. The Commission would consist of 15 members; 2 of the 15 would be physicians. Their report is to be submitted to the legislature and to the governor. **Active Support.**

A-3593-Zangari—Chiropractic. Defines chiropractic as "the adjustment and manipulation of the articulations of the spine and related structures and whose purpose is the relief of certain abnormal clinical conditions of the human body causing discomfort resulting from the impingement upon associated nerves." Also, creates a separate licensing and regulatory board. **Action Deferred,** pending discussion of S-3203 (introduced too late for July 18 Council meeting). S-3203 will be presented to the Council at its September meeting.

A-3603-Rocco—Reimbursement for Physiological Laboratory Services. Provides that physiological laboratories performing diagnostic testing services at the request of physicians shall be permitted to bill Blue Shield directly. **Disapproved,** because there are no announced licensing standards in the bill. The NJ Insurance Department is not equipped to regulate and license a health pro-

fession. There is no recognized profession related to "physiological laboratory services."

A-3634-Walker—Cancer Research Fund. Provides for a surtax on cigarettes to be used for cancer research through the Commission on Cancer Research. **Approved.**

A-3646-Vainieri—Second Surgical Opinions. Prohibits physicians from performing elective surgery unless the patient has secured a second surgical opinion prior to the surgery. **Active Opposition,** because the majority of patients are referred to surgeons by family physicians, pediatricians, and internists. The universal requirement of a mandatory second surgical opinion would be disruptive, dangerous, and unnecessarily expensive to patients and their insurance carriers.

A-3661-Walker—Infant Mortality. Clarifies the content of A-2129 regarding maternal services to add nurses and home health agencies as eligible providers. **Approved.**

AJR-94-Ranieri—Professions. Creates a commission to study, evaluate, and make recommendations regarding the regulation and licensing of the professions. **No Action.**

AJR-97-Garvin—Cardiac Rehabilitation. Creates a Cardiac Rehabilitation Services Study Commission to study the alternatives available to bypass surgery. **Disapproved,** because the evaluation of alternative methods of treatment to bypass surgery requires the experience, judgment, and training of cardiologists. Since patients having bypass surgery are referred to surgeons by medical cardiologists there is a well functioning check and balance in the system. This bill is both unnecessary and dangerous.

AJR-98-Garvin—Second Surgical Opinions. Directs the Department of Health to study whether second surgical opinion programs should be required through HMO coverage. **No Action.**

AJR-126-Cooper—Outpatient VA Services. Requests the Veterans Administration to establish an outpatient clinic in central or southern New Jersey. **No Action.**

ACEP Resolution

The following resolution was passed by the American College of Emergency Physicians at their national convention:

Whereas, Rudolf E. Schwaeble, M.D., has represented the New Jersey Chapter of the American College of Emergency Physicians in this Council since 1973; and

Whereas, Rudolf E. Schwaeble, M.D., has represented his Chapter and the interests of all emergency physicians and their patients with honor and dignity for 12 consecutive years; and

Whereas, Rudolf E. Schwaeble, M.D., has functioned as the conscience and historian of the Council

and has graciously shared his perspective with other councillors; therefore be it

Resolved, that the 1985 Council and Board of Directors of the American College of Emergency Physicians commend Rudolf E. Schwaeble, M.D., for his dedicated service to emergency medicine.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—John Junior, M.D., 9315 Ridge Blvd., Brooklyn, NY 11209. Wroclaw (Poland) 1980. Also, internal medicine. Board certified. Group, partnership, solo. Available February 1986. S.H. Emami Kelishadi, M.D., 4201 Cathedral Ave., NW 222E, Washington, DC 20016. Tehran (Iran) 1957. Also, emergency medicine. Group or partnership. Available.

CARDIOLOGY—David A. Gehring, M.D., P.O. Box 5610, Hobbs, NM 88241. University of Pittsburgh 1956. Also, internal medicine. Board eligible. Board certified (IM). Group or partnership. Available.

DERMATOLOGY—Steven Fenichel, M.D., 337 S. Harvey, Oak Park, IL 60302. Royal College of Surgeons (Ireland) 1976. Board certified. Solo, partnership, group. Available.

EMERGENCY MEDICINE—S.H. Emami Kelishadi, M.D., 4201 Cathedral Ave., NW 222E, Washington, DC 20016. Tehran (Iran) 1957. Also, anesthesiology. Group or partnership. Available.

FAMILY PRACTICE—Debra T. Miller, M.D., 1428 D Mews Dr., Kansas City, MO 64131. Hahnemann Medical School 1982. Board eligible. Group or partnership. Available.

Susan F. Stickels, M.D., 1913 E. Kenmore Pl., Shorewood, WI 53211. Board certified. Group or HMO. Available.

C.C. Enu, M.D., c/o Dr. Foins, 291 Decatur St., Brooklyn, NY 11233. Albany Medical 1969. Board certified. Group, hospital, partnership, HMO.

David A. Gehring, M.D., P.O. Box 5610, Hobbs, NM 88241. University of Pittsburgh 1956. Also, cardiology. Board certified. Board eligible (CARD). Group or partnership. Available.

INTERNAL MEDICINE—Irving S. Gottfried, M.D., M.P.H., 5700 Centre Ave., #1014, Pittsburgh, PA 15206. St.

George's University (Grenada) 1981. Board eligible. Group, partnership, solo. Available July 1986.

John Junior, M.D., 9315 Ridge Blvd., Brooklyn, NY 11209. Wroclaw (Poland) 1980. Also, anesthesiology. Board eligible. Board certified (ANES). Group, partnership, solo. Available February 1986.

Anil Kapoor, M.D., 332 Lincoln Dr., Haworth, NJ 07641. All India Medical Institute 1966. Board eligible. Solo, partnership, group. Available.

Mark S. Noveck, M.D., 6807 Bonnie Ridge Dr., Apt. T-2, Baltimore, MD 21209. New York Medical College 1980. Board eligible. Group or partnership. Available.

Kevin W. O'Hara, M.D., 2250 Mt. Carmel Ave., Apt. A-2, Glenside, PA 19038. UMDNJ-New Jersey Medical School 1982. Board eligible. Group or partnership. Available May 1986.

Alka J. Patel, M.D., 1 John Och's Court, Saddle Brook, NJ 07662. Topiwala National Medical College (India) 1983. Board eligible. Group or partnership. Available July 1986.

NEUROLOGY—Kala L. Paul, M.D., 921 Marine Dr., #113, Galveston, TX 77550. University of Texas 1981. Board eligible. Group. Available February 1986.

OBSTETRICS/GYNECOLOGY—William King, M.D., 9112 Abigail Dr., #1-C, Baltimore, MD 21237. Wayne State 1975. Board eligible. Group, partnership, HMO, hospital based. Available.

James E. Veintimilla, M.D., 9 Wolfpack Ct., Trenton, NJ 08619. Ecuador 1957. Board eligible. Small-town practice. Available.

PULMONARY—Harlan R. Weinberg, M.D., 337 N. Palm Dr., Apt. 8, Beverly Hills, CA 90210. University of Connecticut 1981. Board certified. Also, board certified (IM). Hospital. Available July 1986.

SURGERY—Eduardo Harley, M.D., 177 Lincoln Blvd., Kenmore, NY 14217. Cayetano Heredia (Peru) 1975. Board certified. Also, oncology surgery. Group, partnership, solo. Available.

Lance A. Lieberman, M.D., 2046 76 St., Brooklyn, NY 11214. Rutgers 1980. Board eligible. Also, vascular surgery. Solo, group, partnership. Available July 1986.

Niranjan V. Rao, M.D., 3311 Clarendon Rd., Cleveland Heights, OH 44118. M.R. Medical College (India) 1976. Board certified. Also, vascular surgery. Group, partnership, solo. Available January 1986.

UROLOGY—John R. Scheuch, M.D., 116 Sycamore Rd., Jersey City, NJ 07305. St. George's University (Grenada) 1981. Board eligible. Partnership or group. Available July 1986.

Edward C. White, M.D., 5 Starlight Ct., North Babylon, NY 11704. Guadalupe (Mexico) 1979. Board eligible. Solo, partnership, group. Available.

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Tuesday, Feb 18

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Wednesday, Feb 19

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ANTONIO JORGE MESSINA, M.D.
Santo Domingo, Dominican Republic

Management of Facial Skin Cancer
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Everywoman's Health: The Complete Guide to Body and Mind, 3rd Edition

D.S. Thompson, M.D., (ed). New York, NY, Doubleday & Company, 1985. Pp. 823. Illustrated. (\$19.95)

Doctors Thompson and Greenman have assembled a distinguished panel of women physicians who have contributed chapters to a very comprehensive guide covering practically every aspect of a woman's physical and emotional health. The appendices contain supplementary explanations, definitions, and a directory of health information that could not be appropriately included in the individual chapters without tedious repetition.

Although the information is presented from a woman's perspective, it does not indulge in the "bra-burning" fantasies and strident anti-male rhetoric that characterize many popular books with literary and scientific pretensions. The simple, straightforward advice that is offered reflects the sensible and sensitive attitudes of these mature scientists and their collaborators and editors.

There are three minor criticisms

offered not to diminish the value of this excellent guide but as a consideration for the fourth edition:

(1) The expectations of the less sophisticated reader may be raised too easily by the paragraph dealing with preconceptional advice for choosing the baby's sex.

(2) Insufficient emphasis has been placed upon increased infertility due to tubal disease after years of careless sexual encounters, especially since there are few reliable remedies to this heartbreaking situation.

(3) Only the most meager advice is offered to enable patients to differentiate between vulva-vaginal and urinary infections and thus save women from unnecessary office and pharmacy visits with a few simple, inexpensive home remedies.

This book is recommended not only for all women but for any physician who feels that every minor gynecologic and urologic complaint need not be referred promptly to a specialist.

Jerome Abrams, M.D.

Malpractice: Managing Your Defense

Raymond M. Fish, Ph.D., M.D., Melvin E. Ehrhardt, M.D., Betty Fish, M.S.W. Oradell, NJ, Medical Economics Books, 1985. Pp. 226. (\$24.50)

This unique handbook is written by a physician, a physician-lawyer, and a crisis counselor. Its three chapters, glossary, and table of case citations offer nonattorney readers valuable insight into the dynamics of unfamiliar legal proceedings and much practical advice.

The authors premise their book on the belief that a defendant physician who is familiar with the litigation process and who works closely with the defense attorney in preparing his case will come through the litigation process with less emotional trauma than the physician who reacts with avoidance or anger.

Perhaps the most valuable sections of the book are those dealing with the physician's testimony during deposition and trial. However, readers should be aware that the discussion is general in nature and that court rules governing the giving of testimony both in and out of court differ among the states. Readers

should be cautioned against adopting wholesale the authors' suggested answers to potential problem questions without first discussing the questions and proposed answers with the physician's own defense attorney.

Hundreds of legal case citations are offered to assist the physician's attorney in mounting a defense. While these cases may be of interest to the physician and his attorney, readers should be mindful that every case is factually unique and that a state trial court is not likely to recognize cases from outside its jurisdiction as legal precedent.

Many volumes have been written in recent years on the subject of medical malpractice, the insurance "crisis," and the cause and prevention of malpractice suits. This book meets the previously unmet needs of the physician-defendant confronting a medical malpractice suit.

James E. George, M.D., J.D.

Office Practice of Skin Surgery

Bryan C. Schultz, M.D., and Peter McKinney, M.D. Philadelphia, PA, W. B. Saunders Company, 1985. Pp. 183. Illustrated. (\$34.95)

Drs. Schultz and McKinney wrote this book for practicing dermatologists, housestaff, and general practitioners as a practical guide to the surgical treatment of skin lesions. They limit their discussion to defects that can be closed by a simple advancement technique and do this following a regional approach. A second section of the book discusses the most common skin lesions by pathological diagnosis with an emphasis on aesthetic results. Dividing the book in such a manner gives the reader a reference on practical information regarding a certain lesion in a specific location.

The novice practitioner also will find valuable information on how to set up a modest facility for such skin surgery within a regular office setting.

The text is clear and concise, and the illustrations are excellent and to the point.

This 183-page book, in my opinion, is a must for every general practitioner and will benefit everyone dealing with the care of lesions of the skin.

Robby Meijer, M.D.

***Drs. Applebaum;
Bernstein; Chapelle;
Hawkes; Leonard;
Leonard; Marshall;
Vidal; Vogel***

Dr. Irving L. Applebaum

We just have been informed of the death of Irving Loren Applebaum, M.D., a South Orange internist, who retired and lived in Hallandale, Florida, on November 22, 1982. Dr. Applebaum was 77 at the time of his death. A native of Newark, he received his medical degree from New York University School of Medicine in 1928. He was a member of our Essex County component and of the American Medical Association. Dr. Applebaum was a Fellow of the American College of Physicians, of the American College of Cardiology, and of the American College of Chest Physicians. In 1978, he was a recipient of MSNJ's Golden Merit Award, honoring his 50 years as a physician.

Dr. Israel J. Bernstein

Israel Jacob Bernstein, M.D., a member of our Essex County component, died in July 1985. Born in New York City, in 1914, Dr. Bernstein was graduated from the Faculty of Medicine, University of Melbourne, Australia, in 1945. He practiced general medicine in Newark at the same address for almost 40 years. Dr. Bernstein was a Fellow of the American Academy of Family Practice. He had been affiliated with Newark Beth Israel Medical Center and St. James Hospital, also in Newark.

Dr. Hayward W. Chapelle

We just have learned of the death, in 1982, of Hayward W. Chapelle, M.D., formerly a member of our Passaic County component. Born in 1902, in Clinton, South Carolina, Dr. Chapelle received his medical degree from Meharry Medical College, in 1940. A general practitioner, he established an office in Paterson, where he practiced until ill health forced him to retire. Dr. Chapelle had served on the New Jersey State Bureau of Children's Services.

Dr. Dudley F. Hawkes

President of the staff at The Medical Center at Princeton, Dudley Farland Hawkes, M.D., was killed in a plane crash in Washington Township, on October 3, 1985, at the untimely age of 49. Born in Newark, Dr. Hawkes received his medical degree from New York University School of Medicine, in 1963. An orthopedic surgeon, he practiced in the states of North Carolina and New York, before coming to New Jersey in 1971. He became a member of our Mercer County component, and of the American Medical Association. Dr. Hawkes was board certified in his specialty, and in addition to his affiliation with The Medical Center at Princeton, he had served as a consultant to Princeton University.

Dr. Bernard F. Leonard

After a lengthy illness, Bernard Francis Leonard, M.D., died at his home, on October 5, 1985, at the age of 71. Born in Newark, Dr. Leonard was graduated from Hahnemann Medical College and Hospital, in 1940. A family practitioner, Dr. Leonard maintained an office in Burlington for almost 40 years. He was a member of our Burlington County component and of the American Medical Association. Dr. Leonard had been affiliated with the Memorial Hospital of Burlington County, Mount Holly, and served on the Burlington City Board of Health for 40 years. He was a school physician in Burlington City's public school system for 25 years.

Dr. Frederick S. Leonard

Frederick Sylvester Leonard, M.D., a family practitioner for many years in Tenafly, died September 24, 1985, at the age of 75. A native of Cascade,

Iowa, Dr. Leonard earned his medical degree at Georgetown University School of Medicine, and was graduated in 1935. He was a member of our Bergen County component and of the American Medical Association, and had been affiliated with Holy Name Hospital, Teaneck, and Englewood Hospital.

Dr. Henry D. Marshall

At the advanced age of 80, Henry Donald Marshall, M.D., a retired family practitioner in Atlantic City, died on September 9, 1985. Born in that same city, Dr. Marshall was graduated from Howard University College of Medicine in 1932. He was a member of our Atlantic County component, and of the American Medical Association. Prior to his retirement, Dr. Marshall had been chief clinical assistant in the medical outpatient department at Atlantic City Medical Center.

Dr. Augusto L. Vidal

A psychiatrist from Belle Mead, Augusto L. Vidal, M.D., died at Somerset Medical Center, Somerville, on September 23, 1985, at the age of 68. A native of La Paz, Bolivia, Dr. Vidal received his medical degree from the University of San Andres School of Medicine, La Paz, in 1945. He emigrated to the United States in 1948, but on several occasions returned to his native land to work with the Bolivian Red Cross, and the La Paz Health Center. Dr. Vidal was a member of our Somerset County component and of the American Medical Association. He had been affiliated with Somerset Medical Center, and was board certified in psychiatry and neurology.

Dr. Nathan F. Vogel

A retired family practitioner in Springfield, Nathan Freud Vogel, M.D., died on September 30, 1985, at the age of 74. Born in Newark, Dr. Vogel received his medical degree from the medical school of the University of Vienna, Austria, in 1937. He was a member of our Union County component and of the American Medical Association. Dr. Vogel had been affiliated with Overlook Hospital, Summit. During World War II he served for four years with the medical corps of the United States Army.

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JANUARY TO DECEMBER 1985

NEW JERSEY MEDICINE

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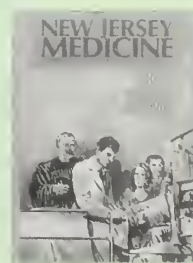
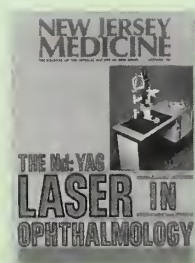
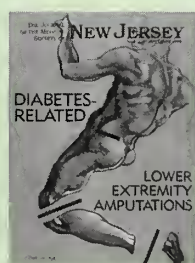
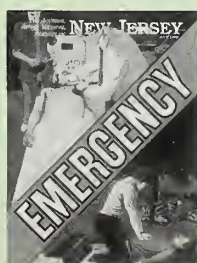
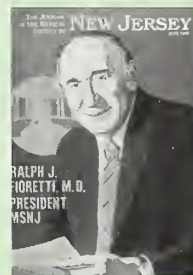
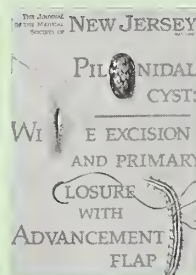
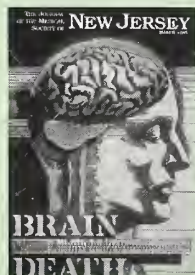
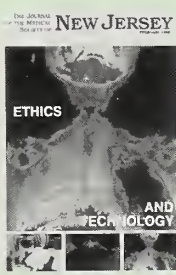
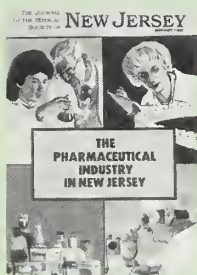
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ACKNOWLEDGEMENTS

NEW JERSEY MEDICINE, The Journal of the Medical Society of New Jersey, acknowledges the contributions of the members of the Editorial Board (whose names are listed on the title page of each issue) for

their assistance in evaluating scientific manuscripts. *NEW JERSEY MEDICINE* also wishes to thank the following Ad Hoc Reviewers and Book Reviewers for 1985:

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Ruttenberg, Max, M.D.	+417

S

Sall, Jack, M.D.	+337
<i>Salmonella Typhi</i> in the United States via Travelers, Introduction of—Sussman; Karp; Rubinstein; Boulis	*655
Sama, Jahir, M.D.	*531
SBME—Proposed Regulations	bt906
Scanlan, David B., M.D.	+337
Schlesinger, Esther, M.S.W.	*795
Schmidt, Rina, M.D.	*531
Schmitt, Michael A., M.D., M.P.H.	*217
Scoles, Peter S., M.D.	+253
Scranton, Charles W., M.D.	+917
Seaton, R. Kirk, M.D.	+837
Selected Jewish Views of Life and Medical Practice—Lindenthal; Michelson; Schlesinger	*795
Seltzer, Jacob, M.D.	+549
Semen Donors—Smith	le490
<i>Sex Talk for a Safe Child</i> —Hansen	br251
Seynold, Arthur D., M.D.	+764
Shaikh, Khaleel, M.D.	cr641
Shapiro, Eli	*787
Sharma, P.V. Pathanjali, M.D.	cr316
Shpetner, Aaron F., M.D.	+337
Simon, Philip H., M.D.	+253
Siroty, Robert R., M.D.	cr535
Smith, Leon G., M.D.	sa389
Solk, Arthur G., M.D.	+170
Solomon, Louis, M.D.	+495
Solomon, Sheldon D., M.D.	*143
Somers, Anne R.	cm807
Spindell, Lloyd, M.D.	*464
Sports, Committee on Medical Aspects of	bt748
Sports, Research in the Physiology of Exercise and— Novich	sa295
Stanford, Paulette, M.D.	*817
Stapling for Morbid Obesity, Three-Year Experience with—Brolin; Greenfield; Kasnetz; Clemow	*127
Stephenson, James B., M.D.	*381
Sternoclavicular Pyarthrosis—Farrer	cr735
Strauss, Arthur, M.D.	+495
<i>Streptococcus Bovis</i> Endocarditis and Bowel Neoplasm—Murillo; Bendersky; Titelbaum	cr665
Strong, Michael D., M.D.	cr44
Stybel, Joseph, M.D.	+690
Subordinated Loan Certificates	bt323
Sullivan, Claude C., Jr., M.D.	+417
Summers, Alfred D., M.D.	+417
Sussman, Norman, M.D.	*207
Sussman, Sidney J., M.D.	*655
Sylvia, Lawrence C., M.D.	cr41
<i>Symptoms and Signs in Cardiology</i> —MacMillan ..	br833

T

Talty, John C., M.D.	+495
Tambascia, John J., M.D.	+337
<i>Teaching Atlas of Mammography</i> —Horner	br546
TEFRA	bt235
Telephone: Hazard to Hearing, Cordless—Westerman; Gilbert	*729
Three-Year Experience with Gastric Stapling for Morbid Obesity—Brolin; Greenfield; Kasnetz; Clemow	*127
Threshold Attainers—Teaze	le757
Threshold Attainment: A New Medical Specialty— Goldstone	op475
Thymoma, Cervical—Robbins; Peacock	cr221

<i>Thyroid and Its Disease, The, Fifth Edition</i> — Singer	br169
Titelbaum, Jules A., M.D.	cr665
Tolor, Stanley, M.D.	+337
Tophus, Intraosseous Gouty—Mahapatro; Sylvia; Becker	cr41
Topilow, Arthur A., M.D.	*471
Transurethral Prostatectomy: Analysis in a Community Hospital—Affuso	*960
<i>Trauma and Pregnancy</i> —Abrams	br546
Trends in Teenage Pregnancy—Chatterjee, Heim	*375
Trombetta, William L., J.D., Ph.D.	hg869
Trooskin, Stanley Z., M.D.	*367, cr739
Trustees' Minutes	66, 148, 235, 323, 404, 483, 677, 748, 906
Tumor Lysis Syndrome in a Patient with American Burkitt's Lymphoma—Topilow; Hershkovitz; Krumerman	*471
Tumor Marker, Aspirated Foreign Body Acting As— Pokorney; Ayvazian	cr395

U

Ulcer Undetected by Angiography, Carotid—Sharma; Corwin; Vogel	cr316
UMDNJ Notes	67, 149, 236, 326, 405, 484, 539, 679, 749, 822, 907, 967
<i>United States Coastal Charts, 1783-1861</i> —Hall	br251
Unusual Occult Bronchial Foreign Body, An— Halpern; Morgenstein	cr393
Unusual Pharyngeal Perforation—Rothman	cr671

V

Van Buskirk, Arthur	*723
Vandersluis, Harold H., M.D.	+170
Vascular- β Adrenoceptors—Brostrom	*59
Vena Cava with Synthetic Graft, Replacement of Lacerated Superior—Olearchyk	*881
Verhoek-Oftedahl, Wendy, M.S.	*723
Vics, Erika, M.D.	+84
Vidal, Augusto L., M.D.	+978
Viral Diagnostic Lab—Frenkel	le684
Visualization of the Gallbladder in a Case of Acute Cholecystitis on Hepatobiliary Imaging—Ghiatas; Makhija; Averbach	*212
Vogel, Nathan F., M.D.	+978
Vogel, Roy A., M.D.	cr316
Vol-Tretter, Marta, M.D.	+837
Volvulus, Acute Gastric—Yee; Dwyer	cr311
Volvulus of the Gallbladder—Budd; Fink	cr803

W

Wahba, M., M.D.	cr661
Waller, Alfonso H., M.D.	+337
Ware, Carl N., M.D.	+417
Watson, Frank Y., M.D.	451
Weiss, Kenneth J., M.D.	*141
Westerman, S. Thomas, M.D.	*729
Whitken, Albert I., M.D.	+690
Whitman, Lloyd B., M.D.	+549
Wiesenfeld, Benjamin, M.D.	+170
Wilkerson, William G., M.D.	+84
Wilson, Lawrence A., M.D.	+253
Withers, George R., M.D.	+84
Woltz, Sidney, M.D.	+764
Women Membership, Ad Hoc Committee on	bt66
Wulfsohn, Mendley A., M.D.	cr963

Y

Yates, Glen L., M.D.	+917
Yee, Jack, M.D.	cr311

Z

Zeig, Norman J., M.D.	*303
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AUTHOR INFORMATION

New Jersey Medicine is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published in New Jersey Medicine is copyrighted by MSNJ.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompanying material offered to *New Jersey Medicine* must contain the following language and must be signed by all authors:

"In consideration of *New Jersey Medicine* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *New Jersey Medicine*.

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the

source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *New Jersey Medicine*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

NEW JERSEY MEDICINE

Publisher: Medical Society of New Jersey
Advertising Office: 609-393-7196

Advertising Representative:
(pharmaceutical)

Advertising Representative: Cookson Media Services, Inc.
(non-pharmaceutical) 370 Morris Avenue
Trenton, N.J. 08611
609-393-7196

United Media Associates
16 Bruce Park Avenue
Greenwich, Conn. 06830
(203) 661-9702

General Information

1. Issuance:

- a. Frequency: Monthly
- b. Issue date: 10th of month
- c. Mailing date: 10th of month

2. Established: 1904

3. Organization Affiliation:

Official publication
Medical Society of New Jersey

4. Circulation Data:

a. Controlled circulation to all members of Medical Society of New Jersey. Member's subscription (\$10) is included in Society dues. Rates for nonmembers \$20, outside USA add \$7.50 for postage. Single copies \$2.

b. Annual percentage of subscription renewals: 100% of members.

c. Number of issues sent after subscription expiration: None.

5. Special Issue:

Index (December)

6. Editorial Content:

Membership Newsletter, Professional Liability Commentary, Editorials, Physician Legal Bulletin, Hospital Governing Boards, Scientific Articles, Special Articles, Case Reports, Commentary, Contemporary Clinical Nutrition, Impaired Physicians Program, Medical News and Meeting Notices, Trustees' Minutes, State Legislation, Annual Meeting, Medical Insurance, Continuing Medical Education, JEMPAC Reportorial, Review Articles, State-of-the-Art Articles, The Electrocardiogram, Non-Invasive Cardiology, Pediatric Briefs, Clinical Notes, Your Congressman Speaks, Doctors' Notebook, Letters to NEW JERSEY MEDICINE, Personal Items, Obituaries, Book Reviews, Medical Histories.

7. Requirement for Acceptance of New Professional Products for Advertising.

All advertising subject to Publication Committee approval.

8. Requirement for Advertising Clearance:

All advertising subject to Publication Committee approval.

9. Advertising Acceptance of Nonprofessional Products or Services:

All advertising subject to Publication Committee approval.

10. Policy on Placement of Advertising:

Advertising is interspersed throughout the publication. All R.O.B. ads are rotated each month. Advertising and editorial material is not placed on the same page.

11. Advertiser's Index:

None.

12. Services to Advertisers:

Availability of editorial reprints: Please direct such requests to the Managing Editor.

13. Staff:

Editor: Arthur Krosnick, M.D.; Managing Editor: Geraldine R. Hutner; Assistant Managing Editor: Dorothy J. Griffith; Executive Director: Vincent A. Maressa.

14. Circulation:

All members of Medical Society of New Jersey.

15. Guaranteed Circulation:

All members of Medical Society of New Jersey.

16. Circulation Verification:

Publisher's statement, postal receipt verification.

17. Rates Per Thousand:

Based on the 12-times rate of \$450.00 and circulation of 10,500: \$42.85.

NEW JERSEY MEDICINE

Rate Card effective January 1986

18. Coverage and Market

a. Coverage: All members of the Medical Society of New Jersey, plus trade circulation.

b. Family Practice	1,989
Internal Medicine	1,839
Surgery	933
Pediatrics	660
Radiology	441
Orthopedics	428
Anesthesiology	425
Psychiatry	417
Ophthalmology	383
Ob/Gyn	255
Dermatology	245
Urology	247
Cardiology	231
Neurology	219
Pathology	198
Otolaryngology	186
Industry/Administration	169
Allergy	95
Emergency Medicine	79
Rehabilitation Medicine	59

c. Trade Circulation:

Non-member physicians	
Medical libraries	
Medical schools	
Drug manufacturers	
Medical book publishers	
Medical abstract services	
Advertisers	
Advertising agencies	
Subscriptions	
Total approximately	650

d. Readership Survey: Readership surveys by Health Industries Research and FOCUS show that NEW JERSEY MEDICINE is extremely well read. Copies are available upon request.

19. MEMBERSHIP CIRCULATION BY COUNTIES OF STATE OF NEW JERSEY

Atlantic	228
Bergen	1,222
Burlington	306
Camden	594
Cape May	39
Cumberland	107
Essex	1,625
Gloucester	112
Hudson	449
Hunterdon	84
Mercer	529
Middlesex	665
Monmouth	573
Morris	550
Ocean	303
Passaic	704
Salem	56
Somerset	187
Sussex	79
Union	927
Warren	59
TOTAL	9,398

Guaranteed Circulation: 10,500

NEW JERSEY MEDICINE

Rate Card effective January 1986

Rates

20. Issuance:

- a. Frequency: Monthly
- b. Issue Date: 10th of month
- c. Mailing Date: 10th of month

21. Closing Dates for Space:

- a. Reservations: 1st of month preceding month of issue
- b. Cancellations: 6th of month preceding month of issue

22. Agency Commission:

15%

23. Cash Discount:

2%, 10 days

24. Black and White Rates:

1 time 3 times 6 times 12 times

1 page	\$490	\$480	\$470	\$450
1/2 page	\$255	\$250	\$245	\$240
1/4 page	\$130	\$128	\$125	\$120
1/8 page	\$ 70	\$ 65	\$ 63	\$ 60

Classified: Available to member physicians only

25. Earned Rates:

Rates based on number of insertions used within one year, regardless of size. Space purchased by a parent company and subsidiaries is combined for accounting of earned rates.

26. Color Rates:

- a. Standard color \$165 plus earned black and white rate.
- b. List of standard colors: AAAA standard red, green, blue, yellow, orange.
- c. Matched Colors: \$200 plus earned black and white rate.
- d. 4-color rate: \$550 plus earned black and white rate.

27. Bleed

No bleed charge.

28. Inserts:

- 60 pound coated only.
- 2 page furnished inserts—2x b/w rate; 4 page furnished inserts—4x b/w rate.

29. Preferred Position Rates:

- a. Preferred position rates quoted on request and subject to availability.
- b. Should an advertiser insist on a specific position, production requirements may dictate premium rates.

30. Miscellaneous:

- a. Contract requirements: All contracts subject to publisher's approval.
- b. Statement of guarantee of uniform rates and discounts to all advertisers using same amount and kind of space: No exceptions to published rates.
- c. Concessions: None.
- d. Rates subject to change with 90 days notice. Contracts accepted with understanding that rates will be guaranteed for three months beyond last issue closed. In the event of rate increase, contracts may be terminated without penalty of short rate.

NEW JERSEY MEDICINE

Rate Card effective January 1986

Mechanical Requirements

New Jersey Medicine is printed by offset.
Trim size: 8 x 11

31. Plate Sizes:

Page Unit	Dimensions (width x depth)
1 full page	7 x 10
½ horizontal	7 x 4⅞
½ vertical	3⅝ x 10
¼ vertical	3⅝ x 4⅞
⅛ vertical	3⅝ x 2⅜

32. Bleed Sizes:

Page Unit	Dimensions (width x depth)
1 full page	8⅞ x 11¼
½ horizontal	8⅞ x 5⅝
½ vertical	4⅞ x 11¼

33. Insert Requirements:

Untrimmed size—8¼ x 11¼
Quantity—11,500

34. Paper Stock:

Covers: 80-pound. Inside pages: 55, or 50 pound.

35. Type of Binding:

Perfect bound.

36. Halftone Screen:

Up to 133 screen.

37. Reproduction Requirements:

Black and white positives and 2-color advertisements: negatives, camera-ready mechanicals, and art work acceptable.

4-color: film negatives or positive separations and press proof.

Offset film negatives or positives on .002 or .004 stable base materials must have register marks, center marks and trim marks clearly indicated. Each negative must be marked for color and be right reading emulsion side down.

38. Closing Dates:

a. Negatives or positives, camera ready mechanicals, and art work: 10th of the month preceding month of issue.

b. Publication set copy: 5th of month preceding month of issue.

c. Contact advertising office (609-393-7196) if extensions necessary. All extensions subject to approval.

39. Disposition of Reproduction Material:

Material is held for one year and then destroyed.

40. "Dual Responsibility":

Billing directed to the advertising agency at the net rate is approved on condition that the advertiser will accept "dual responsibility" for payment if the agency does not remit within 90 days. Advertising accounts in arrears 60 days will be billed in duplicate to both the agency and the advertiser.

41. Addresses:

Pharmaceutical Sales:

United Media Associates, Inc.
16 Bruce Park Avenue
Greenwich, Connecticut 06830
203-661-9702

Non-Pharmaceutical Sales, general information:

Cookson Media Services, Inc.
370 Morris Avenue
Trenton, N.J. 08611
609-393-7196

Contracts and insertion orders:

Advertising Office
NEW JERSEY MEDICINE
370 Morris Avenue
Trenton, N.J. 08611
609-393-7196

Reproduction material:

Advertising Office
NEW JERSEY MEDICINE
370 Morris Avenue
Trenton, N.J. 08611
609-393-7196

Inserts: (11,500)

NEW JERSEY MEDICINE
c/o Hughes Printing Company
34 North Crystal
East Stroudsburg, Pa. 18301





